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

Citation for published version (APA):

General rights
It is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), other than for strictly personal, individual use, unless the work is under an open content license (like Creative Commons).

Disclaimer/Complaints regulations
If you believe that digital publication of certain material infringes any of your rights or (privacy) interests, please let the Library know, stating your reasons. In case of a legitimate complaint, the Library will make the material inaccessible and/or remove it from the website. Please Ask the Library: http://uba.uva.nl/en/contact, or a letter to: Library of the University of Amsterdam, Secretariat, Singel 425, 1012 WP Amsterdam, The Netherlands. You will be contacted as soon as possible.
Chapter IV

RESEARCH SETTING: THE HOSPITAL

Chittagong Medical College Hospital, the hospital at which I did my fieldwork, is the second oldest among the thirteen government teaching hospitals in Bangladesh. It started as a ‘Medical School’ in 1927, during the British colonial era. Though there was a general hospital established in 1901 and a missionary hospital established in 1904, this was the first training institute for Western medicine in that region. In 1957, the then-Pakistani government upgraded the medical school to a medical college. Initially, the existing general hospital continued to provide the infrastructure for the clinical teaching of the medical college. In 1960, a separate hospital was established with 120 beds and outpatient services. However, construction of the present purpose-built six-storied Medical College Hospital was only completed in 1969, two years before Bangladesh emerged as an independent state. The new hospital, which originally had a capacity of 500 beds, gradually increased its size to 750 beds and finally to its present capacity, nearly 1000 beds, in 1984.

Location

The hospital is located in the port city of Chittagong, about 250 kilometres southeast of Dhaka, the capital of Bangladesh. The hospital itself is right on the bank of the river Karnafuli and overlooks the Bay of Bengal. The hospital campus is nestled in a picturesque hilly setting (Photograph is included in the annex). It is the only tertiary level hospital in and around the Chittagong district. As a result, it caters to the medical needs of over three million people living in an area of about 50,000 square kilometres. In addition to Bengalis its clients also include the tribal population from Chittagong Hill Tracts. Inhabitants of the region of Chittagong speak a unique dialect of the Bengali language.

Present facilities

The hospital has nearly all the major departments of the medical practice, including: Internal Medicine, General Surgery, Orthopaedic Surgery, Obstetrics, Gynaecology, Paediatrics, Psychiatry, Skin and Venereal Disease, Clinical Pathology, Otorhinolaryngology, Ophthalmology, Radiotherapy, Radiology and Dentistry. In recent years, a Nuclear Medicine Centre, Coronary Care Unit, Endoscopy Unit and Kidney Dialysis Unit were also added. On average, there is a daily turnover of 1846 patients in the outpatient service. In-patient services have an average daily turnover of 1339 patients.

However, there are serious constraints in medical and surgical resources, equipment, instruments and manpower. There is always a shortage of medical and surgical resources, including insufficient amounts of medicine, instruments, linen, gauze, bandages, laboratory chemicals, furniture and oxygen. The administrative office stated that the hospital can supply only about 20% of the medicines required every day in the hospital. The number of instruments and equipment of hospital is also far from what is
necessary. For example, in the orthopaedic ward where I did my fieldwork, for an average of 110 patients, there are only 2 saline stands, 6 trolleys, 1 bedpan, 2 oxygen cylinders, 1 stethoscope and 1 electric vacuum machine. To make matters worse, some of the instruments which are there are often out of order.

Though there are some high-tech, modern machines in the hospital, a lack of trained staff and bureaucratic reasons keep some of these machines from being used. For example, a Cobalt-60 machine was bought in 1998 to provide radiotherapy for cancer patients, but the machine has not been used for even one patient because of delays in various administrative procedures. The chronic scarcity of resources is clearly related to the budget constraints: Each year the hospital receives only about half of the proposed budget from the government. Table 3.1 summarizes the trends in budget allocation.

**Table 3.1: Budget trends (in Crore)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Proposed amount</th>
<th>Allotted amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Taka (in Crore)</td>
<td>Taka (in Crore)</td>
</tr>
<tr>
<td>1995-96</td>
<td>5.0</td>
<td>2.40</td>
</tr>
<tr>
<td>1996-97</td>
<td>4.67</td>
<td>2.79</td>
</tr>
<tr>
<td>1997-98</td>
<td>4.27</td>
<td>2.56</td>
</tr>
<tr>
<td>1998-99</td>
<td>5.25</td>
<td>2.60</td>
</tr>
<tr>
<td>1999-2000</td>
<td>6.31</td>
<td>3.15</td>
</tr>
<tr>
<td>2000-01</td>
<td>7.29</td>
<td>3.30</td>
</tr>
</tbody>
</table>

(Source: Annual Bangladesh Government Audit Report: 2001)

In addition to government funding, the hospital also generates some money from cabin rent (the rental of private rooms for patients), patient registration fees, admission fees, ultrasounds, radiotherapy, physiotherapy, ECG fee, ambulance rent and rent from some of the shops and offices on the premises of the hospital. The hospital pays its telephone and electric bills to the respective government departments from its own income. But most of the time, the hospital does not earn enough to pay the full amount due. As the hospital failed to pay its telephone bills for more than a year, the telephone and telegraph office of the government disconnected the telephone line of the hospital two months before I started my fieldwork. Consequently, no one was able to make any phone call from outside or inside the hospital during the duration of my fieldwork.

There is also a shortage of manpower in the hospital. Though the hospital has been upgraded from a 500 bed to a 925 bed hospital, the staffing has not been increased commensurately. The total number of employees in the hospital is 1116. Among them, there are 337 supporting staff (nurses, ward boys and cleaners) and 212 medical staff (professors, assistant professors, registers, assistant registers, medical officers and intern doctors). The remaining 467 employees are non-medical staff who work in various administrative sections. The hospital personnel always differentiate between officers and employees (officer ebong kormochari). To them, there is a clear distinction between officers, i.e. doctors, nursing supervisors and certain of the office personnel, and employees (kormochari), who comprise all other members of personnel.

* 1 US$=56 Taka and 1 Crore= 10 Million Taka
This distinction reflects the class distribution within the civil service in Bangladesh where Class I and Class II personnel are designated officers and Class III and Class IV are employees.

However, in this hospital there are 111 posts still vacant, either because of unavailability of qualified persons, unwillingness of the hired persons to join the post, or because of administrative delays in employing qualified persons. Moreover, there are regular full-time and part-time absences among the appointed staffs. The proper office hours are hardly maintained, and most of the doctors leave the hospital earlier to join their private practices.

A tour of the hospital

A high wall surrounds the hospital compound. As such, entrance is only permitted through two big main gates at the entrance, one of which is always closed. Across the road that runs in front of the hospital, there is a row of shops that include pharmacies, general stores, restaurants, fruit shops and stores for articles that are useful for hospital patients (e.g. pillows, bedpans, glasses, plates).

In the mornings, as I entered the main gate of the hospital compound that was open, I would see beggars and street prostitutes, still asleep behind the closed part of the main gate. Street dogs were their temporary bedfellows. The gatekeeper would soon drive them all out. There is a road, a few hundred metres long, which leads from the main gate up to the hospital. A uniformed gatekeeper with a stick stands in the main gate and controls the flow of the cars, rickshaws and humans who attempt to enter hospital grounds. Visitors other than doctors, medical students, nurses and the patients are not allowed to enter the hospital campus. The gatekeeper has a special eye for distinguishing the hospital staff, patients from the other visitors, based on dress, mannerisms and carriage. Though I was not a hospital staff member or a patient, I was rarely prevented from entering hospital grounds in my rickshaw. The gatekeeper always looked exhausted as he beat random rickshaws (who were clamouring to get into the hospital) on their hoods, telling them to clear the entrance.

There are two two-storied academic buildings for the medical college, one on either side of the road that leads from the main gate up to the hospital. When the road reaches the large six-storied hospital building, it bifurcates. On the left, it leads to the emergency department and the right, to the outpatient department. At the front of the hospital, on the ground floor, there is the big lobby in which there is a bank, a post office, the doctor’s canteen, a newspaper stall, the lifts and the staircases. There are two lifts in the lobby but only one usually functions. The calling switch or the indicator lights of the lift are usually the problem, so it is difficult to know the position of the lift. People usually bang on the metallic door to draw attention of the liftman. Entry into the lift is also restricted and has the same criteria as the main gate, i.e. only staff or patients can use it. I preferred the staircase, which is wide and easy to climb. At the foot of the staircase, there is also another gatekeeper who filters the flow of traffic through it. I often used the stairs, as I had to go to fourth floor of the building to get to the orthopaedic ward, and the third floor to visit the Operation Theatre (OT). The walls of the lobby and the staircase were covered with various colourful posters with the picture of students, doctors or Class IV employees running for office during that year’s elections. Although the surroundings of the hospital are quite dirty, even littered with openly disposed medical waste, the staircase and the lobby are relatively clean.
When I reached the orthopaedic ward on the fourth floor, either by lift or by staircase, I faced another collapsible gate at the entrance of the orthopaedic ward. This gate is usually open except around the time of the professor's round and at night. There is another gatekeeper posted there who regulates the movement of the visitors. In the mornings when I was running a little late, I would find the gate closed while the ward was preparing for the professor's round. The relatives of the patients would be gathered around the gate, requesting the gatekeeper to let them in. The gatekeeper would shout back at them in a very authoritarian voice. However, when I approached the gate he would immediately clear the area and let me in, because he had come to know that I was doing something important in the ward.

The gate leads to a small lobby. To the right there is a classroom for medical students, and on the left there are break rooms for the professors and the senior doctors and a mini-operation theatre. Directly in front is the wide door of the ward. Upon entering the ward, one faces a large hallway with about hundred beds placed in rows, and even more patients then the beds can hold. There are rooms of different sizes and for different purposes in different corners of the ward, but the huge open room filled with groaning and disabled patients is what first captures the attention of the visitor. There is a veranda that runs parallel to the ward on both sides. At the far end of the veranda, there is another smaller entrance to the ward, also with a collapsible gate. (See Annex One for a diagram of the grounds.)

**Ward geography**

Big halls for patients are an important, characteristic element of the architecture of the Chittagong Medical College hospital. A big hallway for the gathering of sick people is found to be an essential element in the history of hospital architecture. Thompson and Golding (1975) discussed the design of the large open halls of ancient Greco-Roman Asklepieias in which patients gathered to dream healing dreams, and where attendant priests converted patients dreams into a therapeutic regimen. The institutions for sick people in the early Christian era also had big halls, however, as mentioned during the discussion of the history of hospitals, those rooms contained not only hospital patients but also people who were aged, infirm, blind, crippled, insane, orphans, paupers, wanderers and pilgrims. Those institutions were designed for performing acts of mercy. Interestingly enough, in the orthopaedic ward we also met people who were aged, insane, orphans, paupers, wanderers or pilgrims. Although hospital with big halls declined in industrialized countries as mentioned by Zussman (1993), the architecture of Chittagong Medical College still followed the earlier traditions of hospital architecture. (Drawing of the floor plan is included in the annex)

Big halls are also an architectural element of bureaucratic institutions in which spaces are allotted and demarcated according to the hierarchy of its inhabitants, as discussed by Rosengren and Devault (1963). There are overlapping spaces that patients, visitors and staff members use; there are spaces which only staff members can use; and there are private spaces that only certain staff of high status can use. Access to different boundaries of the ward for the patients and visitors also varies by the time of day. The behaviour of the staff also changes according to the space. Goffman (1959) discussed how social interactions differ according to space.
The professor's rooms that are just to the right after entering the lobby are spacious, furnished, carpeted and have an attached toilet, while the assistant professor has a single room, without carpet and without an attached toilet. There is a common toilet for the other doctors, which only the doctors can open with a personal key. As one proceeds further through the lobby towards the ward, in the front part there are two smaller rooms on both sides for the registers, then the open ward begins. There are rows of beds lining both sides of the rooms, with a wide passage in between. More than halfway down the open ward, there are again two rooms on both sides. On the left is the room for the intern doctors, containing a large table and few chairs. On the right is a room for the duty nurses. In this room, the records of the patients, trolleys and other equipment are also kept. One interesting feature of this room is that it is the only room that is glassed in with transparent glass. Sitting in this room it is possible to watch the whole ward. Nurses can keep an eye to the ward while sitting there; it is also possible for the supervisors to watch the nurses inside the room. This room was useful for an observer like me, for it gave me the opportunity to withdraw for a while after certain observations and to elaborate my jottings in my field notebook, and at the same time keep an eye on the ward, should something interesting happen.

Crossing this nurses' room, one would see the female section of the ward, which is smaller than the male section. There are fewer patients in this part and many are children and infants. In fact, all patients under 12 years old are placed in the women's section.

At the far end of the open ward there are again a few small rooms. On the left side there is a room for the medical officers and clinical assistant and a storeroom, and on the right side, there is a room for the nursing supervisor. There are no specific rooms for the ward boys or cleaners. The space allocation is clearly related to the status of the group. As Rosengren and Devault wrote:

Each functionary in the establishment has, to a greater or lesser degree, an area of 'front staging' and 'back staging'. The extent of available backstage area appears to be related to status. The higher the status of the personnel, the greater is the availability of a 'pure' backstage area; the lower the status the least available is the backstage region (Rosengren & Devault 1963:279).

Outside the hallway of the ward, on the right, there is a veranda parallel to the ward, at the end of which is the other entrance to the ward. On the left, parallel to the ward, there is a rest room for the duty doctors, a space for prayer and the toilets. There are two toilets and two bathing rooms for men and the same number of toilets and baths for women, in two different enclosures.

Most of the patients told me that during their stay at hospital, their most horrible experience was going to the toilets. Each day, more than one hundred patients and all of their relatives use these four toilets. During the large part of the day there is no running water in the toilet. Many are unfamiliar with how a commode should be used. Moreover, there is a big bin inside the toilet enclosure where the patients leave their leftover food and other rubbish. This attracts the crows, and as mentioned in Chapter One, it is possible to hear the cawing of the crows in between the professor's lecture during the round. It is easy to imagine the foul condition of the toilets by the end of the day.
Officially, this is a one hundred beds ward. In reality, there are only 92 beds but there are, on average, 110 admitted patients in the ward. The extra patients are placed on the floor with a mattress or just a sheet to lie on. These are indicated in records as 'X' beds. The ward is divided into two units of approximately equal size. Beds on the left side of the ward belong to Unit One, and beds on right side belong to Unit Two. There are two different teams of doctors for the two units; however, the nurses, ward boys and cleaners work for the entire ward, irrespective of the units. My field observation was mainly focused towards the activities and the people in Unit Two. Though I concentrated on the patients and doctors in Unit Two, it was not always possible to isolate my observations to only one side of the ward.

A day in the ward

A day in the hospital is divided into three shifts: morning, evening and night. The morning shift lasts from 8:00 AM to 2:00 PM; at 2:00 PM the evening shift starts which ends at 10:00 PM. This is then followed by the night shift, which continues until the morning shift the next day. The timing of the shifts is not precise, but the presence of people, activities and the scenario of the ward gradually change throughout the day, reflecting these different shifts. The following is the description of the happenings in the ward in a typical day.

The morning shift

Around 6:30 AM, the ward boys and the gatekeeper of the night shift start waking up the relatives of the patients. Most of the patients have at least one relative who stays with him or her at night; as a result there are about 100 relatives, both male and female, who sleep in the ward in addition to the 100 or so patients. They sleep either under the bed of the patient or share the bed with the patient. Some of the relatives have already awoken by then, but the ward boys and the gate keeper busy themselves with waking the rest who are still asleep, by pushing or nudging them, or sometimes tapping them on their hip with the stick the gate keeper usually carries. After waking up, the relatives rush for the toilets. Because there are only two toilets for men and two for women, there is always a big queue in front of the toilet. Many men use the toilet of the nearby mosque for washing. Some of them leave the hospital for home, to come back at a later time.

At around 7:30 AM, the ward boys and gatekeeper shout to the relatives to clear the ward. The cleaner starts to sweep and mop the floor of the ward at this time. The duty nurses for the morning shift come into the ward wearing their white uniform. The ward boy of the night shift looks at the wall clock in the nursing room and despairs that the morning shift ward boys still have not shown up. He is grateful when the ward boys and the gatekeeper for the morning shift arrive a few minutes later. The new staff members are angry with those relatives who are still hanging around the ward, and admonish them to leave at once. By 8:00 AM, the ward is more or less 'relative free'; only a handful still remains. The nursing supervisor takes the handover register from the night duty nurse and checks the equipment and medicines. She also takes the complaint register from the night duty nurse, in which the names of the patients who require special attention are registered. She distributes the duties to different nurses by writing them in the duty register. The morning shift intern doctors
also have arrived and chat with the night duty intern doctors. They then go to check some of the dressings they had done the day before. By 8:30, most of the junior level staff for the morning shift arrives in the ward, and the night duty staff leave.

Around 9:00 the two collapsible gates for the entrance of the ward are closed, and remain so until after the professor’s round. Two gatekeepers stand beside the closed gates and will only open them when the doctors arrive. Relatives of the patients gather outside the gate. The nursing supervisor fills up the morning statement sheet, in which she writes the particular details of admission, discharge and operation of the ward for that particular date. Other nurses have taken the files of the patients from the record room and are distributing them to the beds of the respective patients. They also are straightening the sheets on the patients’ beds. The ward boys make sure that all the patients are in their respective beds and that the ward is as clean and tidy as possible.

By about 9:30 the senior medical officers, the clinical assistant, the register and the assistant professor arrive in the ward. They inquire about certain patients and anything new that happened during the night. The professor arrives around 10:00; he sits in his room for a while before starting the round, which starts around 10:30. All the doctors follow him; usually one nurse and a ward boy follow the group with a trolley. The rest of the nurses are busy filling out different registers. The group moves from one bed to another, discussing each case. The professor gives advice about the treatment of some patients and asks for certain patients to be discharged. The clinical assistant and intern doctors take notes. On operation days, which are once a week, there are no regular rounds. The professor and other doctors usually go straight to the operation theatre in the morning.

The round is over by 12:00. The professor goes back to his room. The assistant professor, register and senior medical officers usually follow him there. The clinical assistant goes to his room, and the intern doctors follow him. The nurse returns to her room. The nurses then start collecting the files of the patients from their beds and bring them back to the nurses’ room. The intern doctors and clinical assistant are busy writing discharge orders and operation orders that have been decided during the round. After a while, one of the ward boys serves tea and nasta (snacks) in the clinical assistant’s room, where the intern doctors also are. They eat and gossip about all sorts of personal, political and educational matters. The representatives from the pharmaceutical companies also visit the doctors at this hour, to tell them about their product. By this time, tea and nasta have also been served in the professor’s room. The professor and other senior staff discuss different administrative issues about the ward and hospital, as well as local and national political issues over tea.

The professor leaves the ward around 1:00 PM if it is not an OT (Operation Theatre) day. On these days, he usually stays as long as the operation continues. The assistant professor and senior medical officers leave by about 1:30 PM, unless it is an admission day or an OT day. If it is an admission day (which occurs twice a week), then they go to the outpatient department to evaluate new patients. Only the intern and the clinical assistant remain till the morning shift ends.

The nurses and ward boys take the new orders from the doctors and prepare the patients accordingly. Some are given discharge certificates, some are given new medication and others are given new dressings. The evening shift staff members start to arrive during this time, and by 2:30 PM, the morning shift intern doctors, nurses and ward boys leave. The clinical assistant goes for lunch. The two collapsible gates are
The relatives and visitors of the patients start entering the ward. The hospital kitchen staff serve lunch.

**The evening shift**

During the evening, the atmosphere of the ward is quite different from what it is in the morning. The number of staff members is halved during the evening shift. In the morning, there were about eight nurses; now there are only four. There are only two ward boys, which is also half the number of the morning shift. No senior doctors are present; the duty intern doctors and the clinical assistant are the only doctors who are in the ward during this shift.

Newly admitted patients usually arrive at the ward during the evening shift, after completing all the formalities. The nurse makes a file for the new patients and the intern doctor takes the history and makes a preliminary diagnosis. Though the reduced staff and new patients change the look of the ward, the most visible change during this shift is the gathering of the patients’ relatives. Officially, visitors are only allowed in the ward from 4:00 to 6:00 PM; in reality, they start to enter in the ward as soon as the professor and the senior doctors leave the ward, around 1:30 PM. The gatekeeper remains at the gate until about 3:00 PM and gives selective permission for the relatives to enter in exchange for *baksees* (tip). After 3:00 PM, he opens the gate to everyone, and a flood of visitors enters the ward. By 5:00 PM, the ward is heavily crowded with visitors. Each patient has four or five visitors on average during this time. In addition to the relatives, different traders also enter into the ward at this time. The newspaperman sells newspapers to the patients and the barber comes to shave the patients. The ward is transformed into what one of the cleaners described as a crowded, noisy bazaar.

At this point, the ward is basically occupied by the relatives of the patients. They gossip, eat together and share their stories. The intern doctors struggle to find ways to reach the patients who need emergency dressings. The nurses usually remain in their duty room to complete paperwork and chat. Around 7:00 PM the gatekeepers, cleaners and ward boys again become active. They go to different corners of the ward and start shouting at the relatives in high-pitched voices to clear the ward. The relatives do not immediately start to move; most of them are reluctant to leave. Initially the staff members simply ask them to get out of the ward. After some time, they physically take them by the hand to escort them out. After an even longer period of time, the staff members become arrogant, and begin to push, slap and sometimes even beat the relatives with a stick to make them leave.

By 8:00 PM they manage to have rid the ward of most of the visitors. However, one relative is allowed to stay with the patient during the night. This relative is issued a visitor's slip, which permits him or her to stay with the patients during the night. The cleaners sweep and mop the floor of the ward for the second time that day. Around 8:30 PM, the collapsible gate is again closed. The CA makes a quick round in the ward along with the duty internee doctors to appraise the condition of the newly admitted patients. If there are critical cases, he normally talks with one of the senior doctors over the telephone to determine if the condition required an operation. As the telephone line of the hospital was cut because of overdue of the telephone bill, in these cases he usually uses mobile phone. In some exceptional cases, the professor is requested to come to the ward. But generally, the CA himself manages the ward and
gives the necessary instructions to the junior doctors and nurses. He then retires to his room and reads a medical book. The intern doctors either retire to their rooms, chat for a while or go to the mini-OT adjacent to the ward to dress the wounds of newly admitted patients. The kitchen staff serves dinner to the patients. The nurses and duty doctors for the night shift appear in the ward. The night nurse takes the handover registers and checks to make sure all equipment and supplies are present. The CA gives instructions to the newly arrived internee doctors. The CA and evening shift internee doctors and nurses leave around 10:00 PM. During admission days, and when there are emergency operation cases, the CA leaves the ward as late as 1:00 AM.

The night shift

The ward again looks quite different. Most of the staff members are gone. Only one or two intern doctors and one or two nurses remain. One ward boy and an aya are present; they roam the ward, talking to the patients and their relatives. The internee doctors come to the nurses’ room. They chat with them for a while. If there are no emergency cases, the intern doctors leave the ward for a while to have dinner at a nearby restaurant.

Around 11:00 PM, most of the patients and relatives are preparing for sleep. Most of the relatives make a separate bed under the bed of the patient, though some share the patient’s bed with the patient. By 12:00 PM, most of the patients are asleep, though some are awake and sit leaning against their relatives. One father has taken the head of his sick son on his lap; he is awake while the son sleeps. The ward is much darker; single bulbs in two corners of the ward are all that remain lit. The noise of the ward is also lessened, though some patients groan or cough and some relatives snore. A dog barks outside; a cat crosses the floor of the ward. A male nurse and a female nurse chat in their duty room. The two intern doctors who returned from dinner around 1:00 AM go to the resting room for the doctors. One goes to sleep and the other reads a book. The nurses also go back to their resting room.

At 3:00 AM, a road traffic accident patient suddenly arrives. A ward boy goes to the doctors’ resting room and calls for one of the doctors. An internee doctor comes and looks at the patient who has severely injured his leg. He asks the ward boy to take the patient to the mini-OT. Because of the noise of the arrival of the new patient, some patients rise up from their sleep and try to follow what is happening. One of the internee doctors goes to the mini-OT and dresses the new patient’s wounds, assisted by a nurse. After a while, the other intern doctor also joins the procedure. After the application of the dressing, the ward boy helps the patient to be placed on the floor, as there are no empty beds left. Other nurses check the saline drips of some of the patients. Around 5:30 AM, the mosque sounds the azan, the call to prayer. It is still dark outside. Some patients and relatives wake up and prepare to say their prayers. By 6:30 AM, most of the patients and relatives have awoken, and are readying themselves to face another day.