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 V

PATIENTS: LOST IN THE LABYRINTH

Let me return to Kabir, whom I introduced in the first chapter. His two hands had been cut off by people hired by his cousin with whom he was having a dispute over a piece of cultivable land. When I entered the ward the day after his admission, Kabir greeted me. He was relatively calmer than the day before, when I had first met him. He drew my attention to the local newspaper and told me: ‘Sir, see here is my story in the newspaper. The journalists came yesterday night. See, I am neither a criminal nor a political party activist.’ I had already seen a report on him in the local newspaper with a picture of him with his amputated hands. He proceeded to tell me that there were two more patients with amputated hands, who had been admitted the night before. He enthusiastically showed me the beds of his fellow handless patients, as if they belonged to a same team. He did distinguish himself from them, however, by telling me that these two men were political activists and that a rival political group had done this to them.

I asked Kabir: ‘How are you today?’
With a deep sigh he replied: ‘How can I be sir? My life is ruined.’
He asked his wife who was standing beside the bed to give him a glass of water. She poured water in the glass from a jug and helped him to drink. Kabir continued: ‘You see, overnight I have become such an invalid man that I cannot take a glass of water by myself. Yesterday night while I was trying to sleep, an ant entered into my ear. I couldn’t do anything. My wife was sleeping; I had to call her to take the ant out of my ear. You see, now I cannot fight with an ant, daktar shaheb (doctor, sir).’

During his stay in the ward I had several encounters with Kabir, and I saw how this bold, audacious man gradually became a timid, distressed person. He continuously wanted to know whether he would be able to go back to his normal life through the use of artificial hands. He was anxious to know about the cost of them and made plans to arrange the money. In the meantime, Kabir’s family brought a case to court against his cousin. The police could not catch his cousin; he had absconded. Kabir told me that some people came to the ward to talk to him on behalf of his cousin who had fled. They offered him money in exchange for the withdrawal of the court case. Kabir did not agree to this, but he was also not sure whether his cousin would ever be arrested. He thought his cousin might give the police a big bribe to keep them away from him. He was also anxious about how to deal with the case when he is finally discharged from the hospital.

I met the other two men who also had their hands cut off and were admitted to the hospital the day after Kabir was. They were the local leaders of a political party. The situation in their region was tense because of an upcoming local council election. A few days before the incident some members of their party attacked the election procession of their opponent group and wounded them. The group vowed to take revenge. One night when these two leading figures of the party were returning home from a meeting, the rival party members got hold of them and took their promised revenge. About eight or ten people took them to an isolated place near a river and
chopped off their right hands with an axe. They threw the hands in the river and left the two men bleeding on the bank of the river. The men managed to stand up and walk a kilometre through a rice field, despite their bleeding amputations, until they reached a highway, where they waited for someone to rescue them. As it was past midnight, the road was deserted. After a while, they saw a man on a motorbike approaching. They managed to stop him, but as the motorcyclist saw the two blood-soaked, handless men, he became scared, screamed and immediately drove off. They again had to wait for someone to rescue them. Because of their continuous blood loss, they did not have the energy to stand up any longer and lay down beside the road. After a while, a passing police patrol car found them and took them to the hospital.

These two brutal cases that I encountered in the very beginning of my fieldwork prepared me for the shocking incidents that I witnessed throughout the rest of my research. The majority of the patients in the ward, however, are not victims of such violence, but of other kind of casualties. I will provide the case patterns and the patients’ profiles in the subsequent section. From there, I will examine the experiences of the patients: the various kinds of uncertainties, their loss of privacy and dignity, how they cope with uncertainties and monotony as well as some of their happy experiences. (Some photographs showing different aspects of patient’s life in the ward are included in the annex)

Casualties

Types of casualties

A departmental newsletter, *Clinical Orthopaedic & Related Research* (Chawdhury 2001) gives the following list of cases admitted in this ward over a period of six months, from January 1 to July 30, 2001.

<table>
<thead>
<tr>
<th>Place fractured</th>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radius Ulna</td>
<td>384</td>
</tr>
<tr>
<td>Femur</td>
<td>284</td>
</tr>
<tr>
<td>Tibia fibula</td>
<td>190</td>
</tr>
<tr>
<td>Humerus</td>
<td>180</td>
</tr>
<tr>
<td>Hand bones</td>
<td>91</td>
</tr>
<tr>
<td>Foot bones</td>
<td>89</td>
</tr>
<tr>
<td>Clavicle</td>
<td>50</td>
</tr>
<tr>
<td>Pelvis</td>
<td>40</td>
</tr>
<tr>
<td>Patella</td>
<td>37</td>
</tr>
<tr>
<td>Colles</td>
<td>34</td>
</tr>
<tr>
<td>Mandible</td>
<td>12</td>
</tr>
<tr>
<td>Miscellaneous: Rib, Spine, Scapula</td>
<td>11</td>
</tr>
</tbody>
</table>
Table 5.2: Dislocation cases

<table>
<thead>
<tr>
<th>Dislocation sites</th>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shoulder</td>
<td>34</td>
</tr>
<tr>
<td>Hip</td>
<td>30</td>
</tr>
<tr>
<td>Elbow</td>
<td>28</td>
</tr>
<tr>
<td>Knee</td>
<td>2</td>
</tr>
<tr>
<td>Ankle</td>
<td>2</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 5.3: Orthopaedic problems

<table>
<thead>
<tr>
<th>Type of problems</th>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bone tumour</td>
<td>29</td>
</tr>
<tr>
<td>Infection</td>
<td>18</td>
</tr>
<tr>
<td>Club foot</td>
<td>13</td>
</tr>
<tr>
<td>Deformity</td>
<td>7</td>
</tr>
<tr>
<td>Neglect (Maltreated)</td>
<td>38</td>
</tr>
</tbody>
</table>

Table 5.4: Other problems

<table>
<thead>
<tr>
<th>Type of problems</th>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crush Injury</td>
<td>265</td>
</tr>
<tr>
<td>Tendon injury</td>
<td>108</td>
</tr>
<tr>
<td>Amputation</td>
<td>41</td>
</tr>
<tr>
<td>Bullet injury</td>
<td>24</td>
</tr>
</tbody>
</table>

Causes of the casualties

These tables do not indicate the causes of the accidents that brought the patients to the hospital. The doctors are generally interested in the clinical nature of the fracture or injury, and not in the circumstances surrounding the injury. Because I am interested in these, I prepared a list myself, which indicates the causes of the causalities, based on the history as told by the patient. Below is a table that lists the causes of the causalities experienced by the patients admitted in Unit Two at one point of time during my fieldwork.

Table 5.5: The causes

<table>
<thead>
<tr>
<th>Type of cases</th>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Road/Train/Water/ Traffic accident</td>
<td>22</td>
</tr>
<tr>
<td>Accident at work</td>
<td>10</td>
</tr>
<tr>
<td>Physical assault/Violence</td>
<td>9</td>
</tr>
<tr>
<td>Fell from height/ Slipped on ground</td>
<td>8</td>
</tr>
<tr>
<td>Congenital deformity</td>
<td>2</td>
</tr>
<tr>
<td>Bone tumour</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>52</td>
</tr>
</tbody>
</table>

The table shows that traffic accidents are the most frequent cause of admission, followed by occupation-related accidents. A Bangladeshi national daily newspaper (Daily Janakantha, 8 January, 2002) reported recently that countrywide, there are an average of seventy deaths everyday due to road traffic accidents. Table 5.5 also shows that criminal violence-related cases...
are third in number, followed by accidents due to a fall. There are few cases of congenital deformities or bone tumours. This table gives a relatively more detailed picture of the casualties faced by the patients; but even this list does not tell the whole story, for it is not known how the casualty actually occurred. The following are a few brief accounts the patients related about their casualties.

The stories behind the casualties

The examples below help to give an idea of what kind of injuries the patients in the orthopaedic ward have sustained. There are similar stories behind all of the broken bones of the ward. The pattern of cases is more or less the same throughout the year, though there are some seasonal variations. In the winter and during the rainy seasons, there are more road traffic accidents, probably because of foggy weather and slippery roads. In the summer, particularly in the month of June, a number of young children who have fallen from trees are admitted in the ward. I later realised that June was the mango season, and that children frequently fell from trees while in pursuit of mangos.

The assistant professor told me that there has been a remarkable increase in the number of crime-related cases in recent years. He said: ‘When we were young and in training in the orthopaedic ward, we hardly saw gun shot cases or amputation of limbs by assault. There were occasional cases, once in a while. But now almost every week such cases are admitted. In last five to ten years, crime in the society increased extremely.’

Traffic accidents

Gafur is a day labourer. Every day he travels from his village to the city to find work. He takes the commuter train to the city. Because he does not have enough money, he usually does not buy a ticket for the train. To avoid the ticket checker he climbs up to the roof of the train while it is moving, where other ticketless passengers ride. He has done this for years. On the day of his accident, he tried to jump from the roof of one compartment to another while the train was moving, which he had also done before. But on that day he fell in the gap between the two compartments, and his legs were crushed.

Jasimuddin drives a lorry, although he does not have an official driving licence. He travels all over the country transporting goods. On his last fatal trip, he was carrying a heavy machine in the truck, which he was supposed to deliver to another corner of the country. The trip had already taken three days; he was supposed to have reached his destination by the second day, but his journey was delayed because of several traffic jams. Though he had not slept during his second night on the road, he did not take a break to nap because he was already late. Though he felt sleepy, he continued driving. Past midnight, on the third day of his trip, he smashed into a roadside tree. He was trapped in the truck; his hands and legs were broken. People from the nearest village came to rescue him and brought him to the hospital.

Rahamat is a folksinger. On his way back from a music show, he crossed a highway at a point not designated for road crossing. A bus hit him and fractured his legs.

Accidents at work

Riajuuddin is a mason. He was working on the construction of a high-rise building. He used no supports or braces while he was working on the roof nine storeys above the ground. He fell and fractured both of his legs.

Sobhan works in a ship demolishing industry. This is an industry where old, out-of-order ships are broken down into pieces and then are sold as raw material. While Sobhan was cutting off a part of the ship with an electric saw, a big piece of iron fell on his leg. His leg was broken.
Babul is a worker in a noodle factory. His hand slipped into the machine and his fingers were cut off.

**Physical assault and violence**

Abdur Rob is a schoolteacher. A young boy from a neighbouring locality wanted to marry his daughter who attended college. But Abdur Rob rejected his proposal as the boy was disreputable and not well educated. The boy persisted proposing to the girl. Abdur Rob threatened to inform the police. One day when Abdur Rob was walking on a deserted road, the boy approached and beat him with a stick. His right hand was broken.

A young boy, Farid, took the wrong train when he wanted to return home after a day of selling peanuts in the street. He had a quarrel in the train with a group of boys his age who were regular passengers on that train. At a certain point one of the boys pushed him from behind. He fell off the moving train and cut his leg.

Rashida Khatun’s family had been disputing with a neighbouring family about various issues. One morning, while she was feeding her cow, the neighbour came to her house. He complained that the vines of her bean tree had climbed the branches of his mango tree. He then kicked her in her hip. Rashida’s hipbone was broken.

Ranjit Chakma, a tribal peasant was gathering wood in the hills when he got trapped in the crossfire between the soldiers of Bangladesh army and the tribal armed rebels. A bullet injured his right leg.

**Slip from ground or fall from height**

Enamul Haque is an elderly man, who slipped on the floor of the toilet and broke his hipbone. Roksan climbed a mango tree along with her other friends. The tree was wet and slippery. She fell and fractured her hand.

**The patients’ profiles**

In this section, I will present some background information of the admitted patients.

**Gender of the patients**

Table 5.6 below gives the gender of the patients.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>45</td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>52</td>
</tr>
</tbody>
</table>

Of the 52 patients, 41 were adult males, 5 were adult females and 6 were children below 12 years, of which only 2 were girls. Usually young children below 12 years of age occupy most of the beds in the female part of the ward. The small number of female patients in the ward is remarkable. 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. Though 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 much exposed to the dangers that can cause orthopaedic causalities.

**Age of patients**

The age of patients ranged from 2 to 75 years old. Table 5.7 below gives the age profile of the admitted patients.

<table>
<thead>
<tr>
<th>Age range</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-12 Years</td>
<td>7</td>
</tr>
<tr>
<td>13-20 Years</td>
<td>11</td>
</tr>
<tr>
<td>21-30 Years</td>
<td>18</td>
</tr>
<tr>
<td>31-40 Years</td>
<td>4</td>
</tr>
<tr>
<td>41-50 Years</td>
<td>3</td>
</tr>
<tr>
<td>51-60 Years</td>
<td>4</td>
</tr>
<tr>
<td>61+</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>52</td>
</tr>
</tbody>
</table>

The table shows that majority of the patients are within the age of 13 to 30 years of age, and the largest category is from the age group of 21 to 30 years. This can be explained by the fact that this is the most mobile and active age group, who are therefore most often exposed to road traffic accidents and work related causalities, which can cause orthopaedic problems.

**Occupational background**

Table 5.8 below gives the occupational background of the patients.

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driver (truck, bus, baby taxi [a motorized rickshaw])</td>
<td>9</td>
</tr>
<tr>
<td>Factory worker</td>
<td>7</td>
</tr>
<tr>
<td>Helper (truck, bus)</td>
<td>5</td>
</tr>
<tr>
<td>Small business</td>
<td>5</td>
</tr>
<tr>
<td>Day labourer</td>
<td>4</td>
</tr>
<tr>
<td>Student</td>
<td>4</td>
</tr>
<tr>
<td>Housewife</td>
<td>4</td>
</tr>
<tr>
<td>Farmer</td>
<td>3</td>
</tr>
<tr>
<td>School teacher</td>
<td>1</td>
</tr>
<tr>
<td>NGO health worker</td>
<td>1</td>
</tr>
<tr>
<td>Folksinger</td>
<td>1</td>
</tr>
<tr>
<td>Mason</td>
<td>1</td>
</tr>
<tr>
<td>Telephone operator</td>
<td>1</td>
</tr>
<tr>
<td>Religious preacher</td>
<td>1</td>
</tr>
<tr>
<td>Beggar</td>
<td>1</td>
</tr>
<tr>
<td>Children below 12 years</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>52</td>
</tr>
</tbody>
</table>

Table 5.9 Educational level of patients

<table>
<thead>
<tr>
<th>Educational level</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>No education</td>
<td>8</td>
</tr>
<tr>
<td>I-V level</td>
<td>14</td>
</tr>
<tr>
<td>VI-X level</td>
<td>12</td>
</tr>
<tr>
<td>XII</td>
<td>6</td>
</tr>
<tr>
<td>Graduate (2 years study after Higher Secondary)</td>
<td>3</td>
</tr>
<tr>
<td>Master’s (4 years study after Higher Secondary)</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>46</td>
</tr>
</tbody>
</table>
Educational background

The educational background of the aforementioned patients can be seen in table 5.9.

From the preceding tables, it becomes apparent that the patients are mostly from the lower income groups and mostly have lower levels of education. This is to be expected, as government hospitals are generally the cheapest option for Bangladeshi people. Chittagong Medical College hospital is the only tertiary level hospital for thousands of poor people in a vast geographical area.

The uncertainties of the patients

In this section, I will describe in detail the experiences of the patients once they arrive at the hospital. It seems that the patients face number of uncertainties as they enter into the hospital campus.

Which way to go, whom to ask?

Razzak, a 10 year-old boy, had fallen from a mango tree and broken his left ankle. He consulted a local general practitioner before coming to the hospital. As the condition of his leg worsened, the doctor advised him to go to the hospital, which was about 30 kilometres from their city. Accompanied by his father and elder brother, he took a bus to the city. After reaching the city, they took a baby taxi to the Chittagong Medical College Hospital; it was their first time there.

Upon getting off the baby taxi, they found themselves in a huge lobby with hundreds of people. They had no idea which way to go to see the doctor. As Razzak could not walk, his elder brother carried him in his arms and his father looked for the way to the doctor. Someone finally showed them the way to the ‘outdoor’ (outpatient) department. It was 9:00 AM, and there were already a number of people waiting outside the corridor of the outdoor patient’s consultation room. Razzak’s brother laid Razzak down on the floor, while Razzak’s father and brother remained standing, unsure of what to do. They learned that the outdoor doctor was not yet in. After some time, Rahamat Ali, a ward boy whom they never met before, came to them and asked whether they had taken a ticket. They replied that they did not know what a ticket was, so Rahmat Ali asked Razzak’s brother to follow him. Razzak’s brother learned that the ticket is a piece of paper on which the patient’s name, age, sex and address are written, and is sold from a counter in the corridor for 5 taka. Rahmat Ali, the ward boy who showed him the way, told him to give the ticket to the guard in the ‘outdoor doctors room’. He thanked Rahmat Ali for showing him the way, and he replied that he would meet them again after the doctor’s consultation.

When Razzak’s brother returned to his family at half past ten, he saw that by that time many more patients had gathered in the corridor. He gave the ticket to the man who guards the doctor’s chamber. The doctor had still not come. More patients were coming, one after another, further crowding the place. From time to time, the gatekeeper appeared and shouted to the crowd to not gather too close to the door. He also said that he would call the names according to the order of the serial numbers on the ticket when the doctor arrived. Razzak was groaning on the floor. His father and brother were sitting beside him, staring off into space. Some patients sat leaning against the wall, some were lying on the ground, like Razzak. Patients’ relatives were standing or sitting on the bench placed in the corridor. There was an air of impatience. The doctor arrived around 12:00 PM; the crowd rushed to the door as soon as they saw him. The gatekeeper closed the door behind the doctor. After some time, the gatekeeper started to call the names of the patients from the tickets that had been supplied to him. Razzak’s turn came about an hour after the doctor began seeing patients. His brother carried him to the chamber. When they entered the chamber, the gatekeeper closed the door, thereby reducing the noise of the crowd outside. They
saw the doctor on the other side the doctor's desk. The father and his sons stood nervous and silent.

The doctor took the ticket and said: 'So, this is Razzak, the film star. [Razzak is also the name of a popular Bangladeshi film actor.] What happened?'

Razzak's brother said: 'Fell from the mango tree.'

Doctor: 'How many mangos did you take Mr. Razzak?'

They remained silent. The doctor examined the leg.

Razzak's father said: 'Sir, pus is coming out from the wound.'

The doctor got angry. 'What do you expect to come out, some orange juice? When did it happen?'

'One week back', said Razzak's brother.

'What did you do in all these days? Must have gone to a harvanga (bonesetter)?' said the doctor.

'No, sir, we went to a MBBS doctor', said Razzak's brother.

'Don’t tell a lie. Anyway. He needs to be admitted. Take this ticket and go to the next room.'

The conversation with the doctor did not make them feel at ease; instead they became more nervous.

Razzak's brother carried him to the next room; his father followed. Razzak had not said anything; so far, he had only groaned. In the crowd of people in the next room they again saw Rahamat Ali, who had shown them the ticket room. He came with a trolley (gurney) and asked them to put Razzak on it, then told Razzak's brother to take a registration number from the Resident Surgeon (RS). He showed him the RS's room. They pushed the trolley towards the room and stood in a queue to get the registration number. Rahamat Ali left, telling them in a very authoritative, unfriendly manner not to move until he returned. Razzak's family could only wonder what the next procedure would be. They were very happy to get the trolley. After a time, they received a number from the RS and waited for Rahamat Ali to return.

Rahmat Ali returned and pushed the trolley towards the lift. His brother and father silently followed the man, until they reached the doors of the lift. Neither his brother nor his father had used a lift before, and it gave them cause for hesitation. The lift operator called by others as the 'liftman' and Rahamat Ali scolded them for their sluggishness and asked them to hurry. They entered the lift, eyes full of anxiety. They got off at fifth floor and entered the orthopaedic ward. The man gave the ticket to the nurse, and then put Razzak on a mattress on the floor of one corner of the ward. By this time it was about 2:00 PM.

Razzak laid on his back on the mattress on the floor. His father and brother stood beside him, looking around with bewilderment at the series of beds filled with patients with broken limbs. Rahamat Ali was in a hurry, and asked Razzak's brother to follow him to the corridor. While they were in the corridor, Rahamat Ali told Razzak's brother, 'Well, the nurse will tell you what to do, now give me 50 taka quickly, I will have to go to downstairs again.' Razzak's brother was not surprised by the demands of this man, whom he would later learn was a ward boy. He thought the service the man had provided to them was worth payment. Moreover, he knew that a stay in the hospital entailed various kinds of expenditures. However, he told the ward boy that he did not have that amount of money and offered him 20 taka instead. The ward boy demanded 30 taka, and finally they settled on 25. The ward boy did not want to waste time haggling with Razzak's father because he had other clients waiting to be carried on the trolley. After he was paid, he left and Razzak's brother returned to the ward. The three of them, one lying, two standing, remained silent in an unfamiliar setting, waiting for the next thing to happen.

There is a second way to enter the ward, and that is through the emergency department, referred to simply as 'emergency'. As most of the patients in the orthopaedic ward are accident cases, they come straight to the emergency department from the accident site. The admission procedure is relatively quicker there. The truck driver Jasimuddin, who had an accident at
midnight and was taken to the hospital straight from the highway, entered the ward in this way. He had no family members with him, but he did have his helper (the assistant to the truck driver is usually called a 'helper') and a few people from the village nearest to where he crashed as company in the emergency room. It was a tense and terrifying situation. Jasimuddin was soaked with blood, his legs were crushed and he was only semi-conscious. His companions need to get an admission ticket so that the emergency doctor could examine him. Once the doctor wrote an admission note for him, he was admitted. Once admitted, he then needed a registration number. It did not take long, however, as it was past midnight and there were not many patients. A ward boy came with a trolley and took them to the orthopaedic ward via the lift. Jasimuddin was fortunate enough to be given a bed. After delivering Jasimuddin to the ward, the ward boy demanded 50 taka from the people accompanying Jasimuddin. As most of the people took him to the hospital were strangers, Jasimuddin's truck helper therefore dealt with the matter. He was not in the mood to bargain with the ward boy, and found 50 taka in his moneybag and gave it to him. The people from the road who helped to carry Jasimuddin to the hospital left after he was placed on a bed. The helper was the only one who remained. He stood beside the bed, while Jasimuddin lay on the bed half conscious, blood all around him.

*A strange unfamiliar world*

After the patient is given a bed (or a spot on the floor) in the ward, the duty nurse writes his or her personal details in a file that is kept on top of the patient's bed. The patient then waits for the duty doctor to give a diagnosis and determine the course of treatment. It is always unclear how long it will take for the doctor to make a first visit to the patient. It did not take long for Jasimuddin to receive his first visit. There was only one intern doctor on night duty that night; he was taking a rest in the doctor's resting room and came as soon as the nurse called him. It took much longer for Razzak to be diagnosed, even though when he arrived, there were three intern doctors and a CA on the afternoon shift. The CA was on his lunch and prayer break. One of the intern doctors was dressing a patient and the other two were writing operation notes and gossiping in the doctor's room. New patients who had recently arrived, such as Razzak, waited for more than an hour for the doctor's first visit.

When the doctor first meets the patient, he is supposed to take a brief history of the patient, examine him, makes a provisional diagnosis and write a treatment plan and diet in the file. However, in most cases, I found that the history and symptoms are not written in the file, only the diagnosis is. It is written in one line, for example, # (which means fracture) of rt. (right) tibia and the treatment and diet. A study done on the medical record keeping in two tertiary level hospitals in Bangladesh also found that in more than 50% of cases, the record sheets maintained in the hospitals were incomplete (Biswa s 1999).

After the doctor writes the treatment plan, a nurse takes the file back to the duty room, and makes a list of medicines and other items necessary for the treatment of the patient which should be brought from outside. A very limited numbers of drugs are available in the hospital. As a result, all the major drugs required for the treatment are bought by the patient or patient's family from stores outside the hospital. In addition to medicines, patients must often buy the cotton, gauze, saline, needles and other necessary items for the treatment. Patients also need to buy day-to-day necessities like a glass, a jug, a bedpan and even the pillow for the bed. As Razzak's brother told me later: 'We thought as this is a sorkari (government) hospital, sorkar is going to give us everything that is needed. But as I can see the hospital has given us just the floor and the roof above, nothing else.'

The relatives buy all the required things from the stores just outside of the hospital gate. Jasimuddin's family, who arrived about an hour after he was admitted, had to buy all the medicines, injections, saline sets, cotton, gauze and even the blood that was transfused to him. Patients can get free blood from a voluntary blood-donating organisation if s/he is lucky enough
to have the right match and can apply for it well in advance. Jasumiddin had none such luck. He had to buy the blood from a local blood bank.

Razzak’s family had to buy an X-ray plate and bricks in addition to the medicines. Bricks are a curious integral part of the orthopaedic ward. All around the ward, red bricks are hanging by plastic ropes from the arms and legs of the patients. These bricks are used to give traction to the fractured lower limbs. Ideally, metallic weights with specific measurements are used for this purpose, but they are expensive and beyond the means of poor patients. Traction is one of the most important practices in an orthopaedic ward and must be done; using local material as weights enables traction to still be done. A variety of weights can be achieved by using different sizes of bricks. Though it is not precise, the general purpose is served. Ward boys sell these bricks to the patients. They keep a pile of building bricks in one corner of the storeroom for this purpose. Razzak bought two such bricks for a total of 20 taka.

After the initial matters are more or less settled, i.e. the file is made, the history is taken (although in an incomplete way), appropriate treatment is decided on and medicines bought, patients enter into a lengthy, monotonous treatment process in which most patients must remain immobile and confined to bed. The patients with fractured hand are ambulatory but their plastered hands limit their activities. The patients with broken legs lie down at all times with plaster or traction on their legs. Some try to move with crutches. However, all the patients must adjust themselves to a strange new environment and face various unanticipated situations in this unfamiliar context. During this stage, patients pass through various kinds of uncertainties, anxieties and feeling of loss.

Who is what?

The first uncertainty arises from confusion about how the ward functions. It takes quite some time for the patients to understand how the ward operates and to differentiate between the roles and attitudes of the many new people s/he suddenly faces. In the initial days, s/he encounters difficulty in differentiating between the many staff members. Patients struggle to learn the difference between the ward boy and the cleaner, the male nurse and ward boy and between the different kinds of doctors. Patients eventually find their own way of identifying them in the course of time. One patient told me about his strategy:

You can see who is cleaning the floor, who is carrying the trolley. Though the person cleaning the floor sometimes carries the trolley, the trolley man never cleans the floor. You know the nurses, both male and female, because they dress in white. I had some problems recognising the doctors, because they don’t wear white coats. But you can say who is a doctor from their manner of behaviour. They are the bosses of the ward. I know the big doctor is the one who comes in the morning; everyone is scared and walks behind him when he examines the patients. There is a bearded doctor, hujur (refers to a religious person) who is an assistant to him and is in charge of the ward. There are also small doctors, who are learning, because the big doctor always asks them questions and scolds them when they fail to answer. There are medical students, who come in masses and examine us. But I still find it difficult to distinguish between the doctors of Unit One and Unit Two and am confused about which unit I belong to. That day I asked one doctor about my X-ray, he replied: ‘You are Unit One’s patient, I don’t know anything about you, you have to ask Unit One’s duty doctor.’

It also takes some time for patients to understand the ward routine. Patients are expected to behave differently during different shifts. For example, in the morning shift patients are more alert in their movements and activities because this is the time for the professor’s round and all sorts of doctors and students are present during this time. Patients are under scrutiny of many
eyes. In the evening they are relatively relaxed; that is when they are surrounded by many visitors. In the night they again come under the close supervision of the staff members. However, patients find it difficult to shift their mood according to the change of the ward shift. This causes continuous friction between the staff members and the patients.

What is happening with my leg?

Most of the patients are uncertain about their condition. The diagnosis is not of much concern for the orthopaedic patients, because they all come to the hospital with a very obvious injury. Instead, patients are mostly concerned about the treatment plan the doctors have 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. How long they will have to remain in traction? Has a decision been made about their operation? When will they go for their operation? How are they improving? When they will be allowed to leave? The patients live with constant questions. 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. Sometimes the patients direct their questions to the nurse after the round, who usually ignores their questions or tells them to ask the doctor. Usually, one of the intern doctors or the CA later tells them about their condition, though in a vague manner. Doctors say, 'You are improving', 'It will take time' or 'Don't bother much; we are doing what is good for you'. It is generally very difficult for patients to resolve any confusion they may have regarding their condition.

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.

As I was asking him many questions, he finally got the opportunity to tell me about his discovery. He said:

Sir, for a week I am trying to tell everyone that there is something wrong with my diagnosis, but nobody listens to me. I am sure I don't have a problem in my right leg. I still remember when the other bus hit our bus from the left side, it hit my left leg, and I fell down. Then I managed to stand for a while with my right leg. If my right leg would have been broken I could not have stood. I also don't have pain in my right leg. I think this X-ray belongs to someone else; they have given it in my bed by mistake. Now they might operate my right leg by mistake.
Then he showed me the X-rays and as if telling a secret, whispered: ‘Look sir, in this X-ray there is a date but in the other one there is no date. This must be a mistake, I have seen all the X-rays have a date.’

I checked his case with the doctor and found that the X-ray was correct, and there was a date, which Ramjan had not seen. I later explained this to him. Most patients do not examine their medical records as enthusiastically as Ramjan Ali. Many of them are even illiterate. However, ‘Could you tell me how long I will have to hang these bricks in my leg?’ and ‘Could you please ask the doctor when they will discharge me?’ were questions frequently asked of me by patients during my fieldwork. Whenever possible, I tried to provide them with an answer.

I am ruined, how am I going to cope?

The financial loss due to hospitalisation worries patients the most, for their economic loss is manifold. First, there are the expenditures involved in being the hospital. As mentioned before, 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. As previously mentioned, 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. As mentioned, 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 bought by the patients. Injectable drugs and medicines required for operation are almost never available in the ward. Pre- and post-operative drugs are generally very expensive; patients who undergo an operation generally have to spend about 10,000 taka, which is a lot of money for a person at a low economic level. Sometimes, patients even have to buy the same drugs twice, because they go ‘missing’ in the course of the procedure, as they did during Ali Ahmad’s surgery (see also Chapter VI for discussion of dubious dealing of lower-level staff with medicine shops).

Ali Ahmad had an internal fixation (fixing the bone by putting a metallic device inside of it) operation on his femur. The duty doctor gave his relatives a medicine list that contained all the necessities: anaesthetic and antibiotic injections, intramuscular infusion set, roll bandage, gauze cortex and leucoplast (adhesive bandage). After buying the supplies from the shop, they handed them over to the ward boy, who took them to the operation theatre. Ali Ahmed was waiting in the pre-operative room for his turn. Ali Ahmed’s brother and wife were waiting in the corridor outside the OT. One of the doctors then came out of the OT and began to scold his relatives: ‘Two injections are missing. Didn’t you check the medicines while buying them from the shop?’ The son of Ali Ahmed remained speechless for a while, and then finally said: ‘We carefully checked the medicines sir, and they were okay when we gave it to the ward boy.’ The doctor said: ‘I don’t know what you have given to the ward boy. These two injections are missing, you have to give them to us quickly, otherwise we cannot take him to the OT table.’ The doctor left giving them a list with the names of the injections. The brother later told me that he counted all the medicines on the list, one by one, after buying them from the shop. He thinks it was more than likely that the ward boy took those medicines, but he has no proof. He again went to the shop and bought the injections. The first time he spent about 2000 taka, and then he had to spend an additional 150 taka. The doctor told me later:

Though patients make mistakes, I know it is very likely that the ward boy has taken those drugs. But I don’t have time to investigate that. The stealing of drugs by the ward boys, and then reselling them to the shop is an open secret. Administration should look into these matters. Why should I waste my time on it?
There are other sorts of informal payments in the ward, some of which have been previously mentioned. 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 than 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), which I will discuss more in the chapters on lower level staff.

The hospital supplies food for only the patient, so the patients also need to spend money to buy food for their relatives who attend them. Additionally, many patients do not like the food supplied by the hospital; they find the hospital food tasteless and smelly. A number of patients therefore take only the rice supplied by the hospital and buy sauce for it, such as curry, from a restaurant.

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. They try to find various ways to cope with the economic loss. The injured drivers or helpers on busses, trucks and baby taxis sometimes get financial help from the owner of the vehicle that they drive. Those who are regular factory or office workers can also claim a part of their hospital costs from their employer. Despite these sources of financial help, these patients still bear the majority of the costs themselves. However, the most financially devastated patients are the day labourers and the small business holders. They do not have any employer to turn to for help. In most cases they do not have any savings, so they take loans from relatives or sometimes from the people for whom once they worked. When such loans are not possible, they sell their property.

Surat 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 six weeks. He had no savings and has earned nothing since he was admitted to the hospital. His wife works as a maid in order to feed their two children. He already had to spend 8000 taka for his operation. He took 10,000 taka as a loan from the owner of the rickshaw that he used to pull. He said: ‘My malik (owner of the rickshaw) was kind enough to lend me the money, but I don’t know how I am going to repay him. If I am able to paddle the rickshaw again, maybe I will be able to pay him back after several months of working, but if I cannot recover, Allah knows how I am going to get the money!’

Izzat Mia is a baby taxi driver who, like Surat Ali, also broke his leg in an accident. He said:

My malik didn’t give me money. I looked for loan. But who wants to give a loan to a poor man? Then I told my wife to sell the cow that she was raising. I am managing to buy the medicines and take care of other expenditures in the hospital with that money. But now doctors are saying that I need an operation. That will require 7000 or 8000 more taka; I don’t know how I will arrange that money. Maybe I will have to sell my piece of cultivable land in the village.

Many patients told me that they are economically ruined by the accident and their subsequent hospitalisation. They have lost their jobs, businesses and property, and do not know how they will recover from the loss. There are, however, some arrangements that the hospital can make to support the very poor patients, although the scope is very limited. There is a social welfare department in the hospital, which supports patients who are unable to pay for anything. The
department is run by donations, so the availability of funds depends on the ability of the department to collect donations from different sources. The department is barely able to fund one or two patients from each ward each month. Moreover, the procedure for qualifying for the funding is complicated. The patient has to apply to the department with a form especially for that purpose, which has to be signed by the CA and the professor of the ward. The CA usually selects the patient for the fund according to his subjective assessment. The patients find it difficult to follow the procedures.

Sohorab Ali, a day labourer, was accompanied to the hospital by his brother, who was also a day labourer. Sohorab Ali’s brother brought the appropriate form from the social welfare department. But he could not fill it out because he could not read or write. He was looking for a person who could help them, but everyone was busy. Finally he found two nurses who were gossiping in their room. He approached them and requested them to fill in the form for them. One of the nurses became very angry and started scolding him, ‘Why disturb us? Why should I do it for you? We are not here to fill out forms for you. Get out of here’. But Sohorab Ali’s brother remained standing by their door, requesting their help. ‘What trouble these relatives are’, said the other nurse. However, she finally agreed to fill out the form, albeit with great displeasure. He then had to find who the CA was. The CA was busy following up patients. Sohorab’s brother followed him for an hour and finally managed to get his signature. But after that, he learned that the professor had already left the hospital, so he had to wait for the next day for his signature. He managed to submit the form to the department with the professor’s signature the next day. It was approved, but then he again had to wait for couple of days to receive the money, which was not enough to cover all of the costs.

There are other means by which poor patients sometimes manage to get the necessary medicines. Sometimes relatively wealthier patients buy medicines for them. Sometimes the doctors use the sample promotional drugs given to them by the pharmaceutical companies on them. On one occasion, the CA himself bought all the necessary medicines for a street boy who had cut his leg in a train accident.

Longest days

The average stay of the patient in the orthopaedic ward is two to four weeks. Some however, are discharged within a few days; there are also patients who have to stay for months. Most of them are unable to walk and are confined to their beds. It is a great struggle for them to fight off the monotony of this confinement. As one patient said, ‘Sometimes I feel the clock has stopped. A day seems like a year’. Patients with hand injuries have relatively greater mobility, but that is also limited within the ward. Though admitted patients are not allowed to leave the ward without prior permission, there are patients who violate the rules.

The CA told me of two interesting cases. A beggar was admitted after a traffic accident and was given hip spika, a device that fits around his hip to immobilise it. When he was little better, he would take off the hip spika during the visiting hours and go out onto the street to beg. After making some money, he would return during the visiting hour so that he could blend in with the crowd. He was, however, noticed by a nurse one day and was prevented from making any further excursions. On another occasion, a patient with fractured upper limb was found going out regularly with his plastered hand to watch movies.

Most patients are not as enterprising as these two, nor do they have the ability to move so freely. They have to spend their hours either laying or sitting on a 7 by 5 foot bed. After their initial days of bewilderment, they develop a routine. In the morning they wash and eat their breakfast. Then the round of the doctors begins. During that period they do not have much to do except wait for their turn to be examined. After the professor’s round and before the visiting hour, they have an hour or two when they are left alone and are relatively relaxed. Then, in the afternoon, the visiting hour starts and several visitors come. This is a pleasant break for the
patients. However, again in the evening, after the visiting time is over, the patients return to their own lonely world.

During the times when there are no visitors and no doctors, the patients interact with each other. Humour and fun play an important role at that time. Patients make jokes among themselves. Sometimes one or two patients become the object of the jokes of the other patients. For example, there was an elderly man who was unwilling to stay in the hospital. Every morning he would tell his neighbouring patients that that day was the day he was going to leave the hospital. But in the evening his relatives would come and convince him to stay. The patients around him would make jokes about this. During the round the CA asked him to buy a catheter. But as soon as the doctors left, the patients around him started telling him: ‘Uncle, you are surely not going to buy this catheter, right, because you are leaving today?’ The elderly man would say, ‘You are correct, why should I buy it, because I am leaving today’. However, in the evening his son would come with a catheter and say: ‘Don’t say a word dad, you have to stay few more days.’

Patients make jokes about the doctors. One patient, who was admitted for more than one month, used to copy how the professor talk and behaves. Once I saw him imitating the professor’s round, pretending to scold the junior doctors. It was good source of laughter for the others. Another day, when the doctors were leaving the ward, with the professor in front and the doctors following him, a few patients from the far end of the ward started saying in chorus in a low voice: ‘Left...right...left... left... right...left.’ They were mocking doctors’ army parade-like movements.

Once when I entered the ward during the doctor’s strike, I caught a whiff of sweet-smelling perfume coming from one corner of the ward. I went closer to the corner and asked where the beautiful smell was coming from. The patients initially did not say anything and started laughing to each other. Then one of them unveiled the mystery for me. He told me that because the doctors were on strike, they have not had their dressings changed for the last four days. Some of their wounds started to generate such a bad odour that it was impossible to stand. One of the patients asked his relative to bring a bottle of ator (a perfume used during religious festivals). When the bottle was brought, he poured a drop of ator on all the bandages in that corner. Thus they neutralised the unbearably bad odour coming from their wounds. The incident was a great source of laughter among them.

Some nights I saw patients singing to break their monotony. A love song beside a blood-soaked leg is a strange juxtaposition indeed. However, soon they had to stop singing, because of the objections of the duty nurse. The patient, who is a folk singer, once told me some of the verses that he wrote while on the hospital ward. Part of one song says: ‘Whether you are a poet or a beggar, nobody cares/You are a poor, powerless, patient here.’

One of the things patients share with each other is the story behind their accidents; each patient has a story that brought him or her to the hospital. Each patient can offer a vivid description of his or her accident. I found that when they described their stories to me, they would give every detail. If it was a bus accident, then the patient would tell me what time the bus left the station, who was with him, how the weather was, how crowded the bus was, exactly how it collided with the other bus, how he was trapped inside the bus, and so on. It seems that everyone’s memory paused at the point of the accident. Because this accident has changed their life so dramatically, it is a memorable event. However, it is also worth mentioning that Bangladesh has a very rich oral culture of storytelling.

The question that most occupies patients is ‘Why has this happened to me?’ A number of patients told me that all day long while lying in bed they try to review their whole life. Some of them think that this is a result of some sin or misdeed. Some cannot figure out any transgression, and wonder why God has given him this punishment. A truck driver told me:

I have been driving trucks for the last twenty years. I was always loyal to my master, never cheated with money. Many truck drivers spend their money on drugs, in brothels. I
never touched those things. I don’t know what my fault was. Why should my life be ruined like this?

Patients pass the time with a variety of other activities. Many regularly pray while lying on their beds. In the female ward, women spend a long time combing each other’s hair and gossiping. Children whose hands are free try to play with whatever is available; some draw pictures.

Loss of privacy and dignity

Thomson and Golding discuss how the issue of privacy in hospitals has been the centre of many debates in America and how it has influenced hospital architectural design. One advocate of hospital privacy in America says:

‘Why should patients today have to lose themselves in a hospital dormitory when we don’t do this or want to in any other aspects of our public lives? When we go to hotel we don’t expect to have to sleep in a room with several other people’.

(Thomson and Golding 1975:225)

The demand for privacy in Bangladesh is definitely not as strong as in the West. Bangladeshis do not have problems sleeping in the same room with other people. It is almost impossible for a poor Bangladesh to afford that level of privacy in his or her own personal life. Even so, after being admitted to the ward, they face unanticipated situations that threaten even their broader sense of privacy. As I mentioned before, the ward is an open hall with more than 100 beds placed in rows. The gaps between the beds are generally four or five feet at the very most. Sometimes a mattress is placed in this gap for extra patients when the beds are full. Few patients are fortunate enough to get a small locker beside their bed. There are only 17 bedside lockers; the rest are broken or missing. The patients who get the corner-most bed, with a wall on one side and a bedside locker consider themselves the most fortunate ones because they can have a kind of enclosed, mini-world of their own in this vast open room. No matter the position of one’s bed, everyone’s privacy is still threatened in some way or other.

Using the toilets is one such example of loss of privacy. Most ambulatory patients told me that the one thing they were most disturbed by in the ward was the issue of using the toilets. Almost all patients struggled to avoid using them. As mentioned before, there are four toilets (two for male, two for female) for more than one hundred patients and all of their relatives, many of whom have never used a commode. Running water is not always available. A big bucket in the toilet contains leftover food and other waste; crows are often seen inside the toilet picking through the garbage in the bucket. Though the toilet is cleaned daily, there are periods in the day when the toilet is so filthy that even entering into it is a horrible experience. One patient told me that when he finally entered the toilet that day after waiting in the long morning queue, he could not last there long, began vomiting and returned to his bed without having used the toilet.

Most of the patients in the orthopaedic ward are non-ambulatory; their traction or plasters confine them to bed. These patients have to use bedpans for their toilet needs. I observed that when patients defecate into a bedpan, with the assistance of their relatives, the patients usually keep their eyes closed, probably to avoid embarrassment. Bed curtains are not provided. One patient told me: ‘See, what punishment Allah has given me, now I have to defecate in front of so many people.’

To avoid such a state, most patients try to delay defecation as long as possible. A number of patients defecate only once in two or three days. One patient did not go to the toilet until five days after admission. I found that a strategy patients use to avoid needing the toilet is to avoid food completely, or to just eat very little. A schoolteacher whose hand was broken during an assault said: ‘I was afraid to eat, because then I would have to go to the toilet.'
Public defecation and urination are not uncommon in Bangladesh. It is not unusual to see people in rural areas defecating on the bank of the river, in the city slum areas or along the side of the railway lines. However, defecating inside a hospital ward, surrounded so closely by other people, is experienced as excruciatingly embarrassing by patients. The experiences of Sue Chowdhury (2001), who writes about her embarrassing experiences with using a bedpan in the presence of others in a British hospital, probably hold true for Bangladeshi patients. In stating that seeking privacy for the performance of our bodily function is a universal human trait, she writes:

I was recently admitted to a trauma ward in a major teaching hospital with mixed sex, and four bedded bays. The nature of my injury meant that, for several days, I could not move or be wheeled to the lavatory, so bedpans were the only options. I blessed my constipation, refused the daily offers of Fybogel or Senna, and lied to the nurse about my bowels...Of course, there were bed curtains, which the nursing staff seemed to draw with a particularly energetic flourish whenever they bustled in with a bedpan. But in the solemn hush that then descended on the room, curtains were quite inadequate, however artfully a cringing patient might contract his or her sphincters to produce the matter without the attendant noise and smells.

In addition, the patients are under the scrutiny of a number of doctors, medical students and staff members during the clinical rounds and teaching rounds. When the professor talks about a certain case, 10 to 15 people gather around the patient's bed. They expose the injured part of the patient as the professor demonstrates and examines the damage and talks about its clinical features and treatment plan. The other doctors and students also examine the patient. They generally do not look at the patients face, but rather concentrate on the injury site. Though the doctors sometimes turn to the patient when they need to ask some questions about his/her complaint, the doctors usually refer to the patient as ‘it’, ‘that’, ‘this’, and discuss him or her in terms of to his or her complaint. For example, doctors say: ‘It is a Collies fracture’ (a acture of the wrist), or ‘That is a fracture of the shaft of the tibia’. We might recall similar expressions in the beginning part of Chapter One.

Let us return to the scene in which the professor makes his round in the beginning of the day. For the duration of their examination, patients remained passive and indifferent. It seems they do not know what to do. Some just keep their eyes closed while some stare at the roof. The women feel most embarrassed when a number of male doctors and students gather around her exposed leg for examination. Sometimes they just cover their face with their shari (a woman’s robe) during the examination. If someone hesitates to co-operate with the doctor during the examination, s/he receives a vigorous scolding. As a result, most of the patients remain silent and passive during these rounds and allow others to examine his/her body.

Tajul Islam, a 35-year-old man was lying on his bed while eight fourth-year medical students surrounded him. The assistant professor was giving a clinical lecture. He pointed to Tajul Islam.

'So this is a fractured patella [the bone cup in front of the knee]. The patella coordinates the activity of the quadricep muscles.'

He asked a student: 'What is the term for profuse subcutaneous bleeding?'

The student replied: 'Accymosis.'

The assistant professor said: 'Good. Feel whether there is local rise of temperature, see whether there is inflammation.'

The students then examined Tajul Islam, one by one. Tajul remained silent and kept a vacant look throughout the duration of the examination. None of the student talked with him as they examined him; they only discussed his X-ray.
These were not the only people to examine Tajul. He was a medically interesting case, and needed an operation. The whole day prior to his operation, different doctors and students came to examine him. He kept his leg exposed to the thigh for the most part of the day, so that he would not need to continuously expose it and then recover it each time a doctor visited him. He told me later:

That’s my fate. What to do? Now I am trapped and people are pulling and pushing my body from all sides. I am particularly scared about the big doctor. When he examines me, he catches the very point where I have the most pain and presses it. I feel that my heart will stop, and want to scream aloud. But I cannot because I know he will be very angry and scold (boka) me. I keep my eyes closed and bear it.

Boka (scolding) is one of things that patients receive from all the staff members, from cleaners to professor, 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. I remember the duty doctor scolded a semi-conscious man who had fallen from the roof of a train and crushed his leg, while applying dressings to him.

You fools deserve this kind of accident. You got up to the roof of the train all right. Then who told you to behave like a monkey? Why did you start jumping from roof to roof?'

The man was hardly conscious enough to answer him. Doctors scold patients when they find that the patients did not take the medicine properly or did not do exercise as was indicated, which happens often. Doctors also scold patients if they cry or make sounds during their examination. Patients are also scolded if they show interest in their medical records or ask questions, because the doctors think it is unnecessary.

The nurses also 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. When I approached a patient whom the cleaner had scolded loudly moments before, he told me:

See, how these people behave. He is just a cleaner, and what nasty language he was using to me. He found a banana peel under my bed. But I know that is not the problem. I refused to give him money. If I would give him 10 taka and shit on the floor, I know he would not say a word to me.

On a few occasions I saw doctors slap the patients. One time, the CA was giving a U-Cast (a particular kind of plaster, given for an upper-arm fracture) to a patient. To properly plaster the arm, the patient needs to be seated in a certain position. But this particular patient was unable to maintain the position for long and was moving too much for the doctor's taste. The CA told the patient to sit still several times. When the patient again moved, the CA slapped him on his back. The patient then remained silent and tried to cooperate. On another occasion an adolescent girl refused to enter the operation theatre. She was scared and crying. The family members tried to
convince her but failed. Then the duty doctor came and slapped her in the face. The girl stopped crying and went into the theatre.

Some patients however, actively showed concern about their dignity. Mamtazuddin is a schoolteacher who broke his leg in a traffic accident. Upon admission he was given just a bed sheet on which to lie on the floor, as all the beds were occupied and there were no mattresses left. He felt embarrassed to lie on the floor and requested the doctors and nurses to move him to a bed. The staff told him clearly that he would have to wait for a day or two. Mamtazuddin approached me and whispered in my ear in English, (probably to prove his education and to distinguish him from other patients):

I am a mathematics teacher in Razbari School. My students came to visit me and it was very shameful for me when they saw me in the dirty floor along with all these labourers. I am not rich enough to afford a private clinic, but I deserve some honour.

*The horror of the operation theatre*

Once a week Unit Two has an operating theatre (OT) day; only emergency operations are performed on the same day the patient is admitted. On that day, the professor makes no rounds; most of the doctors go straight to the operation theatre. The patients are prepared for the operation the day before. Operations run from the morning until the afternoon. Although the patients believe that the operation will hasten their recovery and rescue them from their terrible pain, the operation is also a dreadful event for them.

Mohammad Ali, who runs a small grocery shop, broke his left leg in a bus accident. Twelve days after admission, he will have his operation. The day before his operation I talked with him.

Me: How are you today?
Ali: I still have pain. But finally they have decided to operate me. May Allah cure me. But I am also very scared about the operation.
Me: Why?
Ali’s wife: From the day his operation date has been declared, he cannot sleep any more. He gets up in the middle of his sleep.
Me: Why are you scared?
Ali: Whenever I close my eyes, I see myself in the operation room. I see the doctors are making me unconscious, cutting my leg. And when the operation is over, I am unable to recover from the unconsciousness. This thought panics me.
Patient in the bed next to his: Don’t worry, this is nothing. I just had my hernia operated. You will not feel anything. You will just sleep and they will do their job.

Ali received many visitors before the day of his operation. Relatives from distant places came to pay a visit to him. His operation is a special event for them. Everyone consoled him. ‘Don’t worry; all will be fine. We are all praying to Allah’. I spoke with his visiting relatives. They all seemed anxious about the operation, although they were not showing their worry to Ali, and were trying to give him courage instead. One of Ali’s elderly relatives recited Koranic verses and blew the holy air from her mouth all over Ali’s body, particularly on his left leg, which was the one to undergo surgery the next day.

Ali’s brother had brought all the medicines necessary for the operation. The staff had to do a number of preoperative pathological tests, which were all done at laboratories outside the hospital, with the exception of the blood tests, which were done on the hospital premises. They also had to buy blood for him. All of this cost a lot of money. Ali is paying for it with the little savings he had.
On the day of the operation, the nurse arrived in the morning, organised all of the papers related to the operation, took the consent form to be signed and told Ali and his family to be prepared. Ali was not allowed to eat anything. The ward boy came with a trolley and took Ali to the fourth floor, where the operation theatre is situated. Ali’s wife, brother, elderly father and adolescent son accompanied him to the fourth floor. The ward boy told them to call Allah. He took Ali inside the collapsible gate of the OT while the family members remained outside the collapsible gate in the lobby. There were tears on Ali’s wife’s face. They didn’t exchange any words. Ali’s trolley, with Ali still on it, was kept in the preoperative room along with the four other patients waiting for operation. Ali was third in line; there were two minor operations before him. There was dead silence in the room. Nobody talked to each other. I broke the silence by asking Ali if he was scared. He did not answer, but only gave me a blank look. I tried to console him, and told him to not be scared.

At that point, another ward boy came with a trolley in which an elderly lady was lying with her right leg broken. Her sari soaked with blood. She was screaming. She had had an accident a few hours before, and came to the OT from the emergency department. She was shouting: ‘Please don’t do an operation on me. I will die if you take me to the operation table. I will be okay without an operation, I am sure.’ The ward boy scolded her: ‘Don’t shout, otherwise the doctors will cut both your legs.’ The ward boy left her in the preoperative room. The lady saw me and said:

My dear, you are like my son, are you a doctor here? Please don’t take me to the operation room. Please request the doctors to not to do an operation on me. Please keep my word, Allah will bless you’.

I told her that the doctors would see what is best for her.

After an hour, the ward boy took Ali inside the OT. Ali was laid down on the operation table with his arms extended on arm boards. The nurse was busy preparing the linen, cotton wool and dressings that had been autoclaved in separate drums and picked out by lifters. The doctors were busy changing gloves and putting on OT gowns, which are usually white or sometimes ash coloured. All of the staff inside the OT wear white masks. The appearance and the atmosphere inside the OT is quite dramatic.

I asked Ali again if he was okay. Again, Ali said nothing. He was cold with fear. The CA was in charge of the operation, and was assisted by the medical officer and an intern. This procedure was called ‘Open reduction and internal fixation of femur with plate and screw’. The medical officer covered all of the parts of Ali’s body except for the operation site. The anaesthesiologist was busy with the anaesthesia machine. The CA tried to find a vein in Ali’s arm for pre-operative medication. While preparing for the operation the doctors discussed their strike that would take place the next day. After a while Ali was well anaesthetised. The doctors opened the muscle of his leg and started to fix the broken bone with a plate and screw.

While they were doing the operation I left the OT and went to the lobby where his family members were waiting. I saw Ali’s wife in munajat (a praying posture) with tears in her eyes, his father was counting a tasbi (a string of beads for counting the numbers times he called Allah) and his brother and son sitting silently against the wall. They all stood up and approached me with anxious eyes, but they did not ask me anything. I assured them everything was going well, and that Ali’s operation was indeed successful. He recovered promptly from the anaesthesia. When I saw him the next day, he gave me a broad smile and said, ‘By the grace of Allah and doctors help, I might be able to walk again.’

Many patients are not fortunate enough to have such a post-operative smile. Abu Bakar, a 25-year-old man, was the helper of a lorry driver. He wanted to learn to be a driver. His boss, the driver, agreed to give him driving lessons. After six months of lessons he was confident enough to drive the lorry by himself. Abu Bakar then began preparing to apply for an official driving
license. Even though he did not have one, sometimes the driver allowed Abu to drive the lorry so that he could take a rest. Abu Bakar was on one such trip when he had an accident with another lorry; his right leg was completely fractured.

When he was admitted, the doctors asked his family to buy an external fixator (a device to fix the fractured bones externally). It was an expensive device; moreover, they found that it was not available in the city. They needed to buy it in the capital city, Dhaka. It took time to arrange the money and then send a relative to the distant city to buy the device. In the meantime, the doctors kept it bandaged and maintained the dressings. However, after a couple of days the doctors thought it was not possible to wait anymore and decided to operate. When they opened the wound, they found it to be extremely infected. During the operation, the doctors decided that it was no longer possible to keep the leg and that they would have to amputate it. They talked with Bakar’s uncle who was waiting outside of the OT about his condition while Bakar was still under anaesthesia. They asked him to sign a consent form regarding the amputation. Bakar’s uncle had no option but to sign it. Bakar’s foot was amputated from the ankle down. Bakar told me later:

When I gained consciousness after the operation, I found myself again in my bed. I was feeling happy inside. Now I am going to be okay again. Now my dream will come true. I will soon appear the driving license test and have a license. I will no more be a helper but a proper lorry driver’. While I was lying on the bed, my body was covered with a sheet. I had a desire to see my foot. I removed the sheet from my leg, and found nothing was there. I screamed ‘Where is my leg?’ I was shouting to my uncle ‘Where is my leg?’ He didn’t tell me that they had cut my leg. I felt helpless. I cried for the whole evening. All my dreams are gone. My life is ruined.

But I am happy

In the midst of all the dissatisfied voices, there were a few patients who did not complain much about the ward, but were rather happy to be there. Below are the voices of several contented patients in the ward.

Ashraf Ali is a religious man, a Sufi, and works in a shrine. He said:

I have no complaint about the hospital. Why should I complain? We should never complain about life. I am here because Allah wanted me to be here. It is all Allah’s will. Allah sometimes wants us to pass through such difficult times. He tests us, examines our patience and faith. This is an opportunity for me to show Allah my spiritual strength.

Shoeb Ahmed is a schoolteacher. He said:

If I would try I could enter a private clinic, I could have, though with difficulty. I preferred the government hospital. Once my son was admitted to a private clinic for an appendicitis operation. All they want there is money. It is just business. They made all sorts of irrelevant bills. None of these private clinics are proper hospitals. It [the hospital he entered] is just a rented house and they made the dining room of the house into an operation theatre. Moreover, there are just one or two doctors; they decide everything. If you want to call a professor, you will have to wait until it is convenient for him to come, and will have to pay a lot extra. Here at least there are number of doctors, who can
interact with each other and decide about a case. The professor is also available almost
everyday. Yes, the resources are very limited and the behaviour of the staff is very bad.
But what can you expect from a hospital of such a poor country?

Bodor Miah is a beggar. He said:

I have no money. I have no one to help me. They have admitted me, and have given me a
bed. The doctors have arranged medicine for me. Who helps a beggar? I am happy.

Rowashan Ara is female college student. She broke her hand when she slipped on the ground. Her
parents had kept her confined to the house for several weeks to prevent her meeting with her
boyfriend, whom her family does not like. She told me:

My parents didn’t want me to get involved with any boy before my marriage. But in spite
of their objection I continued to meet with him. Then they confined me to the house and
stopped me from going to college. I was not allowed to go out of the house or meet with
anyone for the last month. This accident brought me out of the confinement. Here in the
ward I can meet so many people. It is as if the hospital has brought me freedom from a
jail. I am feeling free.

Discharge

It takes a long time for an orthopaedic patient to be completely cured. As most of the patients are
trauma cases, after they recover from the initial crisis, there is still a long phase during which they
are immobilized and must rest. The hospital usually discharges the patients after the initial
complaints subside. The patients are then advised to rest and to follow the doctor’s instructions at
home. Discharge of the patients is decided during the daily round of the professor. As mentioned
earlier, doctors write the discharge certificate or treatment advice after the round is over, and the
nurses supply the discharge certificates to the patients and explain the instructions to them.
However, because of the extremely high number of waiting patients, many doctors discharge
patients even before they have satisfactorily recovered from the initial trauma. Oftentimes, the
discharge is not properly negotiated with the patients, and as a result there are sometimes disputes
between the staff and the patient.
A nurse handed the discharge certificate to a patient. It seemed that the patient did not
know that he had been discharged.

He said: ‘Why are you discharging me? I am not yet cured.’
The nurse replied: ‘It will take months for you to get cured. We cannot keep you that long
in the ward. Hundred of patients are waiting outside. We have given you the main
treatment. Now you need to rest and do some exercise. Go home and lay down in your
own bed.’
The patient responded: ‘I came to the hospital lying on the trolley, I want to leave the
hospital on foot. You cannot discharge me like this.’
The nurse complained about him to the duty doctor. The duty doctor came and scolded the patient
and asked him to leave the hospital immediately.

Sometime patients are also forced to leave the bed that they presently occupy. An old
man with a fractured hand was discharged in the morning. As the condition of his hand was
reasonably good, he did not object to leaving the hospital, but he told the nurse that he was new to
the city and wanted to wait for his son, who would come to fetch him in the evening. But nobody
paid any attention to his request. A newly admitted patient was placed in his bed and the ward
boy took all the old man’s belongings and put them on the veranda and asked the old man to wait there. The old man remained seated on the veranda with his plastered hand until his son came in the evening.

Some patients, however, leave the hospital with a happy smile. Doctors have saved many severely injured, unconscious victims, such as those who have been involved in a traffic accident. These patients and their relatives are very happy when they are discharged. Another example is the case of a factory worker who was admitted to the ward when a machine cut his index finger. His partially detached finger was hanging from his hand and he was screaming when he first came to the ward. The doctors performed an operation that enabled him to retain his finger in the original position. When he was discharged after two days, he left the ward with a wide smile.

Some patients leave the ward before the doctors have discharged them, after either being frustrated by the treatment procedure or sometimes as a symbolic protest against the humiliation and disregard they are shown. Generally patients can leave of their own accord by giving written consent. But in the case of traffic accidents and other crime-related cases, the patients cannot leave of their own will. These police cases need a proper discharge certificate with treatment indications. If the patient still wants to leave, the staff usually allow him to and records him as an absconding patient. In a few cases, the patient may abscond without informing the staff. Below are two cases where the patients left the hospital as a sign of protest.

Abu Bokor had a fractured femur. The doctors told him that they would do an operation on his leg, but did not confirm when they would do it. After waiting for ten days, he decided to leave the hospital. He told me:

The hospital people keep telling me that soon they will do the operation, but I don’t know when. They do not answer me if I ask anything. I am wasting my time lying here day after day. It is better to lie at home. Finally yesterday they told me to have an X-ray. They said that the X-ray machine of the hospital was not working, so I had to contact a private X-ray laboratory and pay to have it done. So I made an X-ray from a private laboratory yesterday which cost lots of money. But today the doctor said that the X-ray is not correct, that I will have to do it again. Now I am fed up. I don’t want to continue here. My relatives have negotiated with a harvanga kobiraj (bone setter) and I will use his treatment. Please don’t say this to the doctors. They will be very angry. But this kobiraj is very famous, many patients come to him from all over the country. He cured many patients that the hospital failed to cure. I am sure he will be able to cure me.

Abu Bakar therefore left the hospital as an absconding patient.

Jillur Rahman left the hospital the very day he was admitted. The gatekeeper asked his brother, who accompanied him to the hospital, to leave the ward during the doctors’ round. His brother took his time leaving, so the gatekeeper beat him with the stick that he always carries. Jillur Rahamna’s brother left during the round, but as soon as the round was over they told the staff that they wanted to leave the hospital. Jillur told me this on his way out of the hospital:

We may be poor, but that does not mean that we will be beaten by a gatekeeper. I cannot stomach this insult. If needed, I will sell my property and I will get treatment from the private clinic. If I can pay, nobody will dare to humiliate us.

An uneaten hilsha fish

For some patients, all attempts to cure them failed and the patient dies. The relatives who brought a living patient to the hospital leave with a dead body.

Liakat, a twelve-year-old boy who was run over by a lorry while on the way to his school, was brought by his mother and a neighbour to the hospital. He had just said good-bye to
his mother and stepped into a rickshaw in front of their house when suddenly a lorry hit the rickshaw from behind. Liakat fell from the rickshaw and the lorry drove over his abdomen. The accident happened right in front of his mother. His body was crushed from the chest down; he was in shock, though his pulse indicated that he was still alive. Liakat needed oxygen, life saving drugs and saline. The only oxygen cylinder in the ward was being used by another patient in Unit One. The doctor ordered the ward boy to bring the oxygen from the neighbouring ward, and he rushed to fetch the cylinder. The nurse quickly brought the one ampoule of a life saving drug they had in stock and the doctor administered it. But Liakat needed more. In the meantime, Liakat’s father rushed to the hospital from his work place. When he arrived, a doctor gave him the list of drugs and saline to buy as quickly as possible. Liakat’s father ran towards the drug shop, Liakat’s mother, who was waiting in the corridor, cried out loudly to Allah. Liakat began to collapse. The doctor pumped Liakat’s heart; every minute was precious for Liakat’s life. The ward boy came with the oxygen cylinder, and after a while, Liakat’s father arrived with the drugs. But it was too late. Liakat died. The doctor checked his pupils, and declared that he was dead.

Liakat’s father remained standing beside the bed bewildered; the pack of saline and medicines were still in his hand. Liakat’s mother fainted; the neighbour who accompanied her took her into the corridor. The doctor left. The ward boy put the dead body on a trolley and covered it with a white sheet. He kept the trolley in the corridor and told Liakat’s father to wait until the death certificate was issued. The father stood mutely beside the trolley, water falls from his eyes. It took a long time to issue the death certificate. The doctor was busy discussing an operation case with the professor; he only filled out the death certificate form after he finished his discussion. Even then, the certificate remained on the table because it has to be signed by the casualty medical officer, who was in the outdoor patient’s consulting room. The administrative office also needed to be informed. Liakot’s parents waited in the corridor with the covered body of their dead son. The neighbour lighted some agorbati (a stick used in religious functions that produces aromatic fumes when lighted) around the trolley. Liakot’s mother gained consciousness and sat close to the trolley, holding one of its legs. She cried in a low voice about how Liakot wanted to eat a hilsha fish today, which she was about to prepare. The busy hospital staff passes by, other waiting relatives exchange anxious looks.

**Summary and discussion**

In this chapter I have described the experiences and concerns of the patients admitted in the orthopaedic ward. Most of the patients are poor, illiterate, predominantly male, young adults 20 to 40 years of age. They are mostly victims of traffic accidents, criminal violence and occupational hazards. In relation to other illnesses, these musculo-skeletal injuries have the most tremendous impact on the patient, the family and the society in general (Hench 1991). Such injuries result in great physical and psychological pain, limitation of daily activities, loss of independence and reduced quality of life, as well as direct and indirect economic loss. This misery was multiplied in various ways in the case of the orthopaedic patients of Chittagong Medical College hospital. I have described how after the initial shock of being in an unfamiliar place, the patients are lost in a labyrinth of various uncertainties. It is a great hurdle for the poor, illiterate patients to familiarise themselves with the rules and procedures of the hospital administration. Although they manage to find some ways to deal with the official procedures, they remain constantly anxious about their medical condition, as little or nothing is communicated to them about their diagnosis and prognosis. Doctors become angry if patients show an interest in their own medical records. Because the hospital provides little besides the bed and the free consultation, the patients are particularly devastated because of their heavy economic that hospitalisation represents. Patients suffer economic loss due to direct expenditure on medicine and other materials and informal payments, such as those for the limited care and the services they receive from the lower-level staff. They also suffer indirect economic loss due to their inability to work. As a result, most poor
patients are economically ruined by their hospitalisation. They usually use the traditional familial
or patron-client support system to deal with this economic crisis. Patients take loans from kin or
their boss; some must also sell their properties. The poor patients become poorer.

The physically, mentally and economically crushed patients also experience humiliation
from the doctors and other hospital staff throughout their hospital stay. The patients are
incorporated into the organisation at a level lower than any hospital staff. They are scolded and
intimidated by all levels of hospital staff if any breach of conduct is observed among them. Their
privacy and dignity are greatly limited. The patients of the open ward must conduct their private
bodily functions publicly. Moreover, as it is a teaching hospital, patients’ body parts are
objectified and examined throughout the day by different kinds of doctors and medical students.

Despite all these miseries, patients rush to this hospital because it is the only public (and
therefore the cheapest) tertiary-level hospital for thousands of poor Bangladeshi patients. In their
pragmatism, they overtly submit to the domination of the hospital staff, but covertly make jokes
about them, break rules and sometimes even reject hospital care as an attempt to maintain their
dignity. They sing, laugh and tell stories to make their hospitalisation bearable. Many of them
become cured and leave the hospital with a smile.

In general, this chapter depicts the vulnerability and subordinate position of the patients
in relation to doctors and other medical staff in this Bangladeshi hospital. Much has been
discussed about the relational asymmetry of doctor and patient and the dominance of the medical
profession in the practice of Western medicine (Friedson 1970; Lupton 1994; Starr 1982; Wills
1989). These authors argue that the power of medical professionals is maintained by their control
over medical knowledge and autonomy over their work. On the other hand, the Foucauldian
approach stresses that power in the context of the medical encounter is a strategic relation that is
diffuse and invisible (Armstrong 1987). Explicit coercion is generally not involved; the patient
voluntarily gives up his or her body to the doctor’s or nurse’s gaze because that is what they have
been socialised to expect. However, patients, mainly in the West, have been challenging this
medical dominance and demand adequate information about treatment and wanted to be involved
in the decision-making about their care (Annandale 1989; Elston 1991; Fisher & Groce 1985;
Maseide 1991; McKeganey 1989; Wiles & Higgins 1996). But such insistence on a patient’s
autonomy is not observed in non-Western countries; in contrast patients there remained
remarkably subdued (Creighton 1977; Lazarus 1988). As we saw, this was the case for these
Bangladeshi patients. There are number of socio-political and cultural reasons behind this
subordinate attitude of patients in Bangladesh.

There are clear structural obstacles between doctors and patients in Bangladesh in the
terms of their social inequalities. The lower class, poor patients in the government hospital
experience the dominance of the middle and upper class doctors in the same way they experience
the dominance in other spheres of life outside the hospital. Waitzkin (1984) and Navaro (1976)
pointed out that the power relations in the biomedical encounter in a stratified society are related
to the dominance of the middle and upper class doctors and nurses who are in positions of
influence in the medical system. They dominate the lower class and working class, who comprise
the bulk of patients and who have little control over their medical treatment or working
conditions. In connection to this, Waitzkin and Britt commented: ‘Doctor-patient encounters
become micro-political situations that both reflect and contribute to broader social relations,
including social class and political-economic power’ (1989:583).

Although this form of inequality might be observed in various economically developed
countries (as no society has reached complete equality), some societies are more unequal than the
others. In Bangladesh, the difference between the power and wealth of the rich and poor is
extremely large; as a result the hierarchy is also intensely stratified.

Other authors have considered the submissiveness of the patients in non-Western
societies as a pragmatic gesture to maximise their opportunities in an unequal society. For
example, based on her fieldwork in Sri Lanka, Sachs argued that the expectations of biomedicine
that Sri Lankan patients had were different from those of Western patients. She noted that the negative evaluation of asymmetrical medical encounters in the West might partially conceal or make invisible some of its qualities that make it work in other contexts. She wrote:

In Sri Lanka the expectations seem more realistic as to what biomedical care can give in relation to other options. The caste system and the overall asymmetry of power relations in society help people expect what is there for them — and they get it (Sachs 1989:346).

Likewise, the expectations of the Bangladeshi patients are also of a technical kind. Their main aim was to obtain maximum service from this cheapest available public hospital. Not being submissive would reduce their opportunities to obtain what services are available.

Furthermore, Kirkpatrick (1979) pointed out that the demand for patient’s rights and autonomy in the West is connected to the social values embedded in Western culture, where self-sufficiency is cultivated as a desirable personality trait. In Bangladesh, on the other hand, the principle of hierarchy in interpersonal relations is culturally accepted as right and necessary, and is ritualised in many ways. Maloney observed in Bangladesh:

When two people meet in daily intercourse they commonly establish relative rank one way or another; it may depend on wealth, lineage, education, rank of employment, or even a small difference in age. In daily intercourse a person accorded higher rank than another is accorded the right to extract services and respect from him, he provides some patronage in return. Thus, in the moral order reciprocity is expected between the ‘big’ and the ‘little’ people (Maloney 1986:40).

The ‘little’ Bangladeshi patients therefore do not find it unusual when the ‘big’ doctors dominate over them. Yet it is interesting to observe how these patients also sometimes try to maintain their self-respect by covertly resisting the domination through subversion of discipline, humour or by rejecting the hospital care. These everyday forms of resistance are the ‘weapons of the weak’ described by Scott (1985).

The economic loss of the patients due to hospitalisation is linked with the overall poverty of the country. I have described how the hospital receives only half of its required budget, which results in a chronic lack of medicine and equipment supply, as well as a shortage of manpower. As a result, poor patients have to make a lot of formal and informal expenditures to be treated at the hospital. The high concentration of male patients in the ward is also a feature of Bangladeshi society. This fact demonstrates that this is a country where men are the main work force, while women have relatively restricted public life. Fewer job opportunities and value of the Islamic practice of purdah (seclusion) keep women confined mostly within home. As a result they are not the ones exposed to the factors causing orthopaedic problems. Finally, the types of casualties tell us about the society outside the hospital. The stories behind the criminal assault cases reflect the level of violence and intolerance in the society outside of the ward. It is obvious from the stories that these crimes occur in a society where masses of people are fighting over limited resources. One person has his relative’s hands cut off to acquire a piece of land, another attempts to murder his employer for dismissing him from his job, while another breaks his neighbour’s hip with a kick simply because the vines of her bean tree have climbed over his mango tree. The road traffic accident cases show remarkably poor compliance with traffic and motor vehicle laws and at the same time people’s ignorance of traffic rules. The Bangladesh Police Report (1999) also confirms these factors as the main causes of road accidents. The accidents during work demonstrate the poor occupational safety measures mainly for manual workers. Victim of crossfire between government army and tribal rebels reveals the ethnic conflicts prevailing in the country.