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 VI

RELATIVES: SILENT SAVIOURS

I was talking to Abdul Khaleque, an elderly man who had broken his right hand and right leg when a car hit him as he was crossing the highway near his village. He hardly ever came to the city, but now he is trapped in this big city hospital bed with two plastered limbs. As this is harvest season, his two sons are busy in the fields in the village. His wife is taking care of him in the hospital. He told me that his wife stays with him day and night and helps him with everything in the hospital. His sons sometimes come in the evening.

As Abdul Khaleque cannot move his hands, his wife had just finished feeding him breakfast. After a while it was time for the professor’s round. As usual the nurses, ward boys and cleaners all started to shout at the relatives of the patients, telling them to get out of the ward. One ward boy shouted at Abdul Khaleque’s wife to leave the ward quickly. I asked Khaleque where his wife waited during the professor’s round. Khaleque told me that usually she goes out and sits with other relatives in the corridor in front of the operation theatre, but today she is feeling too weak to go out because she could not sleep the night before. Khaleque was having pain in his leg and she remained awake to caress his head.

I left them there and joined the professor’s round. After the round I went back to them and asked Khaleque whether his wife was already back. Khaleque lowered his voice and asked: ‘Is the professor gone out of the hospital, or can he come again to the ward?’ I told him that he was gone and there was no chance of him returning to the ward. Khaleque then whispered: ‘Actually she is just here beneath my bed. I told you that she was very weak; she didn’t go out.’ I was surprised because I had been standing beside his bed for some time but had not noticed anything. Khaleque then asked his wife to come out from beneath the bed. Khaleque’s wife came crawling out from under the bed with a sigh of relief. Luckily, Khaleque’s bed was in a corner of the ward, so it was a good place for her to hide during the round.

As we were talking, Khaleque’s wife reminded him that he needed to take some medicine, which she then helped him with. After some time, an intern doctor came with a slip with a new list of medicines on it and asked Khaleque if there was someone who could bring him these medicines. Khaleque said that his younger son was coming in the evening, and that he would be able to bring such medicines. The intern then opened the bandages over Khaleque’s wound and began redressing them. After a while, the intern doctor said that he needed to leave for a while, and asked Khaleque’s wife to carry on with the washing. He instructed her how to do it. But she found it very difficult to catch the gauze with the forceps. After all, she had never seen forceps before. After the intern left, Khaleque’s wife told me: ‘You see I came with a patient and now they want me to become a doctor.’

It is always possible to see one or more of the patient’s family members in and around the ward. Usually relatives bring the patient to the hospital. In the case of traffic accidents, the patients are brought from the site of the accident to the hospital by strangers, but soon afterwards the relatives arrive in the hospital. Usually one of the relatives then becomes ‘attached’ to the patient during the whole period of the patient’s hospital stay, and plays an important role in caring for the patient. In fact, patients’ family members are crucial players in the overall functioning of the ward. It is generally not possible for the limited number of nurses and ward boys to take care of the more than 100 admitted patients in the ward. Moreover, most of them are engaged in tasks other than the provision of patient care, such as paperwork, gate keeping and bringing tea to the doctors. As a result, although relatives are not part of official organization of the hospital, the staff members heavily rely on them for much patient care. Therefore, relatives are essential actors in the informal organisation of the ward. In this chapter, I will describe the various roles the relatives play in the ward and will examine their experiences in the hospital.
Who are they?

Usually the immediate kin members of the patient act as attendants. In some cases, fellow workers or colleagues also stay with them in the hospital. There are, however, a few patients who do not have anyone to attend them at all. The following tables give information, taken at a certain point during my fieldwork, about the identity of the attendants of the patients.

Table 6.1: Relationship of the attendants to the patient

<table>
<thead>
<tr>
<th>Relation to the patient</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wife</td>
<td>8</td>
</tr>
<tr>
<td>Mother</td>
<td>7</td>
</tr>
<tr>
<td>Father</td>
<td>6</td>
</tr>
<tr>
<td>Brother</td>
<td>6</td>
</tr>
<tr>
<td>Son</td>
<td>5</td>
</tr>
<tr>
<td>Fellow worker</td>
<td>4</td>
</tr>
<tr>
<td>Sister</td>
<td>3</td>
</tr>
<tr>
<td>Uncle</td>
<td>3</td>
</tr>
<tr>
<td>Sister-in-law</td>
<td>2</td>
</tr>
<tr>
<td>Brother-in-law</td>
<td>2</td>
</tr>
<tr>
<td>Father-in-Law</td>
<td>1</td>
</tr>
<tr>
<td>No attendants</td>
<td>3</td>
</tr>
<tr>
<td>Total attendants</td>
<td>49</td>
</tr>
</tbody>
</table>

Table 6.2: Gender of the attendants

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>29</td>
</tr>
<tr>
<td>Female</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>49</td>
</tr>
</tbody>
</table>

Table 6.3: Age of the attendants

<table>
<thead>
<tr>
<th>Age range (Years)</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-30</td>
<td>18</td>
</tr>
<tr>
<td>31-40</td>
<td>17</td>
</tr>
<tr>
<td>41-50</td>
<td>12</td>
</tr>
<tr>
<td>51-60</td>
<td>2</td>
</tr>
<tr>
<td>61-</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>49</td>
</tr>
</tbody>
</table>

Table 6.4: Occupation of the attendants

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housewife</td>
<td>16</td>
</tr>
<tr>
<td>Small business</td>
<td>12</td>
</tr>
<tr>
<td>Student</td>
<td>8</td>
</tr>
<tr>
<td>Farmer</td>
<td>5</td>
</tr>
<tr>
<td>Factory Worker</td>
<td>4</td>
</tr>
<tr>
<td>Government Service</td>
<td>2</td>
</tr>
<tr>
<td>Teacher</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>49</td>
</tr>
</tbody>
</table>

Table 6.1 indicates that the wife, father, mother, brother, or sister most frequently stays with the patient. Sometimes an uncle, brother-in-law, sister-in-law, father-in-law or even a fellow worker acts as an attendant. In these cases, usually the immediate kin are either living far away or were dead. In the case of children under 12 years of age, the attendants were always the mothers. In female wards, all the attendees were female.

Sometimes, however, there is an entirely different kind of attendant: police agents who guard patients who are prisoners. There are always two policemen beside the hospital bed of a convict. They have no emotional
attachment to the patient, yet they must stay there and act as both a guard and attendant.

It is interesting to notice that the majority of the attendants are males. This is contradictory to the prevailing notion in Bangladeshi society that care giving is female work. Patients gave various reasons for the absence of female family members from their bedside. Reasons of inconvenience were most frequently mentioned. It is often not possible for women to leave their household responsibilities; it is also inappropriate for women to stay in the male ward, as mentioned earlier that the Islamic notion of purdah (seclusion) is important for women in Bangladesh. The tables regarding the age and occupation of the relatives show that most of the attending relatives are between the ages of 20 and 40 years of age, and that they are involved in various wage-earning jobs. Thus, a second healthy male must accompany the wounded one, and leave his regular job or business. This has further consequences for the economic life of the family, for additional income for the family is lost. In spite of the economic loss, family members regularly sacrifice their routine life to support their ailing relatives or friends.

**Performing all the crucial tasks**

The attendants perform a number of functions that are crucial to the care of the patients and the running of the ward. The list below summarizes the assistance provided by the attendants to their sick patients:

1. Helping in feeding, washing and toilet
2. Bringing food and medicine from outside
3. Assisting with administering medication and with monitoring exercise
4. Negotiating with hospital staff
5. Intermediary with the outside world
6. Providing emotional support

Orthopaedic patients are generally bed-ridden, so they are very much dependent on their attendants to meet their bodily needs like going to the toilet, feeding and washing themselves. Some of the ambulant patients can walk to the toilet without the assistance of their relatives, but most patients are unable to move to the toilet alone or even at all. In these cases, relatives help them with the bedpan. As mentioned before, the ward boys or cleaners sometimes help the patients with their bedpan in exchange for payment. Many patients cannot even sit by themselves; relatives need to hold them while they sit.
Attendants also feed the patients. Patients with plasters on their hands cannot eat by themselves. Those with leg fractures cannot sit properly to have a meal. In addition to feeding the patients, attendants help them to acquire food from outside the hospital. Most patients said they do not like the food supplied by the hospital, as they find it tasteless. Some of the patients who can afford it request at least some carry out from the nearby restaurant. Others want food from home.

Attendants also help the patient with washing. It is almost impossible for patients to take a complete bath due to their plasters and traction. The attendants therefore regularly wash the patients body by sponging them off with a wet cloth as they sit or lie in bed. I have never seen a nurse or other staff member help to feed or wash the patients.

As previously mentioned, the government hospital has a limited and irregular supply of drugs. As a result, patients have to buy nearly all of the crucial drugs from the medicine shops. The physically disabled patients depend completely upon their attending relatives to go and purchase them. The doctors on duty usually give the attending relative a small slip of paper on which he has written the names of the required drugs. After the relative buys the drugs from the nearby shop, he or she hands them over to the doctor, nurse or ward boy. This is a crucial task; the treatment does not start until the attendant brings the medicine. Likewise, it is imperative for a relative to remain present just outside the operating theatre during surgery, because they are responsible for hurrying to fetch additional medicine or surgical supplies should they be necessary during operation.

Relatives also help to administer medication to the patients. The nurse usually instructs the relatives about the appropriate dose and asks them to follow up the schedule of medication. Illiterate relatives remember the doses according to the colour and size of the tablets and capsules.

Sometimes relatives are asked to assist and monitor the patients’ exercises that the doctor has stipulated they do. For example, some patients are asked to flex and extend their fingers in certain positions five times a day. The relatives are trained how to do the exercise and asked to assist the patient while he or she does the exercise.

It was also interesting to notice that the relatives sometimes dress the patient’s wounds. As the limited number of staff cannot manage to give all the necessary dressings indicated for the day, they sometime train the attending relatives on how to wash the wound with antiseptic or how to apply a new bandage. Nurses and intern doctors usually train the attendants, as was the case with Khaleque’s wife at the beginning of this chapter.

As mentioned in the previous chapter, by bribing the lower staff, it is possible to get preferential treatment in the ward; these negotiations are mostly
done by the relatives. Through bribes and negotiations with the ward boy, relatives can insure that the patients sleeping on the floor will be shifted to a proper bed. Even if the doctor prescribes an X-ray examination, it will not be done unless the ward boy takes the patients to the X-ray department or calls the X-ray machine man to come with the portable machine. These and countless other tasks like bringing the bed pan to a patient in time or being allotted a bed near the window will be accomplished much more quickly if the patient, or the patient’s caretaker, greases the palm of the ward boy or the cleaner.

Relatives are also the medium through which the patient communicates with the outside world. On behalf of the patient, the relatives settle matters with the business, work place and/or academic institution with which the patient was involved. If the patient wants to leave the hospital to receive treatment from a bonesetter or in a private clinic, the relatives must also negotiate the matter with the relevant people.

Most importantly, relatives provide emotional support to the patient. Hospital staff never speak with the patients about anything other than that which is medically relevant, and often not even about that. Instead, patients receive only harsh comments from them for any number of reasons. It is the relatives who console them in their agony. One patient said:

It would have been hell if my brother would not be here with me. There is no one to listen to me, no one to say a few soft words. It is my brother who puts his hand on my head and says to me: ‘Don’t worry every thing will be all right’. My frustrations go away.

However, to the staff members, despite the care they provide to the patients, relatives have a paradoxical position. They recognise the necessary role of the relatives for the functioning of the ward, yet they also consider them as an ‘evil’ of the ward.

A ‘necessary evil’

Relatives receive all sorts of humiliation and criticism by the ward staff. First of all, relatives are said to be unruly and to hamper the normal flow of work. Officially, they are allowed to stay in the ward only between 4:00 PM and 8:00 PM, but they can be seen in and around the ward throughout the day. However, as mentioned before, during the round of the professor, the presence of relatives is strictly prohibited.

It requires great effort to remove the relatives from the ward. The nurses, ward boys and cleaners all start this process one hour before the round starts. They shout, scold and sometimes even beat the patients’ caretakers to
get them out of the ward. The gatekeeper always keeps a stick in his hand for this purpose. Once, when he hit the brother of a patient, who was a college student, with his stick, the young man was very angry and protested. He complained to the doctor, but the doctor took the gatekeeper's side and asked the relative why he had not gone out in time, after the repeated warnings. Another patient told me that the gatekeeper jerked his mother by her neck so hard that she fell down on the floor. A number of relatives told me that they do not feel comfortable leaving their patient alone in the ward. The son of a patient once said:

My father cannot move, I am sure if he wants a glass of water, nobody is there to listen to him. I therefore hang around the corridor during the professor's round and watch my father from a distance through the windows.

Although most relatives wait in the corridor beside the ward during the professor's round, a few also find hiding places inside the ward. Some even take shelter under the bed during the professor's round, as was the case with Khaleque's wife. After the round is over, the relatives again flood into the ward. During the evening the population of the ward reaches its peak.

A second complaint against relatives is that they make the ward dirty. After the hundreds of relatives have left the ward, the floor looks like a wasteland. It is not surprising therefore, that the cleaners of the ward always fight with them. While sweeping up the banana peels, nutshells and empty packs of chips, a cleaner told me:

See what these borbors [barbarians] have done. If you go to the toilet, you will see what they have done there. These stupid attendants of the patients come from the village and do not know how to use a toilet.

Doctors complain that relatives are the source of cross-infection. Relatives are also accused of stealing things from the ward. The nurses, who are responsible for keeping the records of all the materials of the ward, complained that items like bed sheets and light bulbs are frequently missing after the visiting hours. The nurses have a hard time keeping track of the items that belong to the ward and regularly quarrel with the relatives about this.

Finally, doctors and nurses are irritated by relatives because, according to them, relatives ask too many stupid questions and address them to the wrong person. Relatives, who are concerned for the welfare of their patients asked questions about a range of concerns of the patients, such as medicine, food, management of intravenous infusions, bed allocation and so on. One day, when I was sitting in the doctors' room along with some other duty doctors, a relative
of a patient hesitated in front of the doorway. The duty medical officer was writing discharge certificates. The relative continued standing in front of the door without saying anything. At a certain point, the doctor asked in an irritated voice:

‘What do you want here?’
The relative responded: ‘Sir, my son in bed number 82 has a fractured leg.’
‘This is no surprise, this is a ward for the fractured patients. So what?’
‘Sir, he says he is having severe pain in his leg, I asked the nurse but she didn’t say anything.’
The doctor didn’t let him finish the sentence. ‘Do you want your son to dance here? He broke his leg; he will surely have pain. Now get out from here. Who allowed you to enter at this hour, this is not yet visiting hour. Get out of the ward at once.’

The doctor called the gatekeeper and ordered him to make sure that this person left the ward.

Despite their irritation about the relatives, doctors and nurses acknowledged their essential role in the ward. The casualty medical officer said: ‘I can’t stand the relatives but I know that we cannot do without them. I don’t know what to do with them’. A staff nurse stated:

I don’t know how we would manage if the relatives were not there. There are just three of us now. How could we take care of 120 patients, in addition to all this paperwork? Relatives are a disturbance but they are necessary as well. How would all these patients survive without them?

**Daily routine of the relatives**

We have now heard how relatives are perceived in the ward. But how do the relatives experience their stay at the hospital?

In the early morning, the ward boys and the gatekeeper wake up the relatives who are asleep either under the bed of the patient or in the bed with the patient. Those who are slow in getting up from the bed receive a light tap on their hip from the gatekeeper and he asks them to hurry up. They are told to leave the ward quickly for the preparation of the professor’s round. The relatives take some time to finish using one of the four toilets that serve the entire ward. There is usually a big queue in front of the toilet. In fact, as the patients are mostly non-ambulatory, the ward toilets are used more by the
relatives of the patients than by the patients themselves. Many male relatives, however, leave the hospital to use the toilet of the nearby mosque for washing.

After they leave in the morning the relatives are not allowed to enter the ward until the round of the professor is finished in around 1:00 PM. The relatives of some severely ill patients are allowed to stay in the ward, as long as they have prior permission from the doctor. The rest of the relatives find it quite difficult to find a place to stay during this time. During the round, some relatives collect medicines prescribed by the doctor the day before, while some fetch food from a restaurant or from home. Most of their houses are far away, as many of them are from a distant village, so they have nowhere to go. There is a large lobby on each floor in front of the collapsible gate, the gate that is pulled closed during the professor’s round. Most relatives gather in that lobby. They sit on the floor and gossip; some of them fall asleep. Some men go to a nearby restaurant to have tea. This time is particularly problematic for women. They find it difficult to hang around public places when the ward is off-limits. Some resort to hiding under their patient’s bed, as Khaleque’s wife did.

Once the round is over, the relatives become impatient to return to the inside of the ward, and gather around the collapsible gate. They all want to get inside as early as possible. You will remember that after the round is over, the gatekeeper keeps the gate locked for about an hour or two. In this time he uses his authority to give some of the relatives the chance to enter earlier than others. The relatives who are let in early excuse themselves to the other waiting relatives by saying that their patients are in relatively worse condition, and need immediate help. However, everyone knows that these relatives got the privilege in exchange for money, which will be paid later on.

After they are allowed to enter the ward, the relatives are busy for the first few hours. They help the patients to eat their lunch. They also eat lunch themselves. The food is either from home, from a restaurant, or from the hospital. Some very poor patients who cannot afford to buy food from outside eat only hospital food, and oftentimes they must share this with their attendant, even though it is meant for only one person. The kitchen boys who distribute the food are generally kind enough to give extra rice to these poor patients and their helpers. Some of the economically better off patients give their entire hospital meal to the attendant of the poor patients. It was also observed that sometimes a fictive relationship is developed between long-term patients and relatives. They become one another’s sister, brother or uncle, and support each other when needed.

After lunch is over, relatives begin to receive various slips from nurses and doctors with list of medicines that they need to buy or with the name of required pathological tests that need to be done, as decided upon during the professor’s round. Many times I saw that relatives struggled to understand the instructions of the doctors about the pathological tests. Because of the shortage
of ward boys and nurses, sometimes relatives are asked to retrieve the blood or X-ray report from the respective department. I often saw the uncertain faces of the relatives while they stumbled through the bureaucratic process.

In the evening, many more family members visit the ward. The relatives and patients have a good time. The ward is full of visitors; each patient has five or six visitors. On one day I even found nineteen family members and friends gathered around a patient. They gossip loudly and eat snacks together. The staff members frequently refer to the ward during this time as a ‘bazaar’. There are not many regulations that are upheld during this time. The hospital staff are less present during this time, so the patients and their relatives are at liberty to do more or less as they please. At around 8:00 PM, the hospital staff members recommence their task of driving the relatives away.

Only one family member is allowed to stay with the patient during the night. Usually the same relative stays with the patient throughout the course of his or her hospitalisation, but other members sometimes take turns. As it is always noisy inside the ward, relatives and patients usually cannot fall asleep early. The relatives often continue to gossip; they only sleep late at night, after the patient has fallen asleep. Usually young males go to the narrow veranda and play cards. Some share the bed with the patient, but most sleep on the floor under the patient’s bed.

**Being in the kingdom of sick**

When I asked a young man who had been attending his father in the ward for about three weeks how he felt about staying here, he replied:

You are asking me how I feel? How can I feel here? Is it a place people would ever want to stay a night unless they are forced to? I cannot sleep properly, I cannot eat properly, not for the last three weeks. I am taking scolding from staff members on all sides. I have never been humiliated like this in my entire life. I feel that any day I might become a patient. I do not want even my enemy to be admitted to the hospital. But what to do? This is my father. It is my duty to take care of him. He lost his leg in the tragic accident. I accept this suffering.

One young girl who was attending her mother told me:

I am waiting for the day when my mother will be discharged. I feel sick to be present in this nauseating place. I struggle to pass my time here. They do not allow us to stay the whole day in the ward, but there is no place outside to rest either. Being a woman, where should I go?
My house is far away, I cannot spend so much money to go back and come again. It is also embarrassing to stay in front of so many strangers all the time. I feel ashamed to sleep in such a public place. I therefore sleep beneath the bed of my mother. It is better under the bed. I put the mosquito net, which I brought from home, under the bed. It is darker there and I also have some privacy. But still, how can you sleep in such a place? People are groaning all around. Last night at 3:00 in the morning, a road traffic accident patient got admitted. There were so many people. There was blood all around. How can you sleep here?

Another attendant said:

This is miserable for a healthy man to stay in this hospital day after day. I had to close my business to attend my brother here. It is a huge monitory loss for me. But as an elder brother I should look after him. What people will say if I am not beside my brother when he is hospitalised?

A woman who was taking care of her son said:

This is my son; he lost his leg. I don’t think about any of my sufferings or pain while taking care of him. But it hurts (mone kosto pai) when the hospital staff behave so badly with me.

As mentioned, there are also some attendants who are not kin members of the patient. One such attendant is a fellow factory worker of the patient said:

He is not my relative, but he has no one in this town. I must help him. Helping man is helping Allah. Allah will bless me for this.

One police constable, who was attending a prisoner patient said:

This is probably the most difficult duty I have as a policeman. It is a punishment to be here in this hospital. I have nothing to do, what should I talk about with this criminal? Fortunately two of us are here. We gossip, read newspapers and struggle to finish our eight hour shift.

In spite of the humiliation by the staff members, their personal inconvenience and economic loss, family members continue to stay in and around the ward. Their assistance saves both the patients and staff members and keeps the hospital going.
Summary and discussion

Relatives are an integral part of the informal organisation of the ward; they perform various tasks that are crucial for the functioning of the ward. After the admission of the patient, usually one member of the kin accompanies the patient in the ward throughout the period of hospitalisation. This main caretaker provides all kinds of nursing care to the patient. It was observed that closely related kin members, like fathers, mothers, brothers or sisters tend to be the attendants of the patients. It was striking to observe that in contrast to the traditional role of Bangladeshi women as caregivers to the sick, in this ward, more men than women were attending their sick family members. This is again related to the restricted public life of the Bangladeshi women and various practical inconveniences that prevent women from staying at the hospital ward.

The relative helps the patient with feeding, washing and using the toilet. S/he takes part in therapeutic process by helping the patient with medications and dressings. As most drugs and treatment items must be bought from shops outside the hospital, doctors cannot start the therapy unless the relatives go and buy them, and then bring them back to the hospital. The relatives play an intermediary role between the patient and the ward staff and the world outside the hospital. Other family members also regularly visit the patient. They take part in various decisions concerning the treatment of the patient and also provide economic and emotional support to the patients.

From the perspective of the staff, however, family members have an ambiguous position. On one hand, the hospital staff feel that family members are necessary in the ward, on the other hand, they are an obstacle to maintaining discipline and tidiness in the ward. Relatives are accused of breaking hospital rules, of asking too many unnecessary questions and even of stealing things. Relatives are frequently scolded and humiliated by the staff members. The relatives feel that their suffering is more intense because they have to experience all sorts of troubles of hospitalisation even though they are healthy people. However, despite the hassle and torment, relatives remain a silent saviour for both the patients and the staff.

Although family involvement in a kin member's sickness is common in almost every culture (Frank et al. 1991; Litman 1974), the degree and level of involvement varies greatly by the context. For example, the role of family members in a Western hospital contrasts sharply with what has been described here. Family members have limited access to Western hospitals, and they have a limited role to play once the patient has been admitted. When writing about the Mount Hermon hospital in the USA, Coser observes: 'Family and friends belong to past or future, and wear an air of unreality' (1962:4). Once the patient is admitted to the ward, the hospital takes responsibility for him or her.
patient. They take part in various decisions concerning the treatment of the patient and also provide economic and emotional support to the patients.

From the perspective of the staff, however, family members have an ambiguous position. On one hand, the hospital staff feel that family members are necessary in the ward, on the other hand, they are an obstacle to maintaining discipline and tidiness in the ward. Relatives are accused of breaking hospital rules, of asking too many unnecessary questions and even of stealing things. Relatives are frequently scolded and humiliated by the staff members. The relatives feel that their suffering is more intense because they have to experience all sorts of troubles of hospitalisation even though they are healthy people. However, despite the hassle and torment, relatives remain a silent saviour for both the patients and the staff.

Although family involvement in a kin member’s sickness is common in almost every culture (Frank et al. 1991; Litman 1974), the degree and level of involvement varies greatly by the context. For example, the role of family members in a Western hospital contrasts sharply with what has been described here. Family members have limited access to Western hospitals, and they have a limited role to play once the patient has been admitted. When writing about the Mount Hermon hospital in the USA, Coser observes: ‘Family and friends belong to past or future, and wear an air of unreality’ (1962:4). Once the patient is admitted to the ward, the hospital takes responsibility for him or her. The relatives are relieved of the responsibility of care taking. Glaser writes that in Western hospitals:

[T]he visits by family members are regulated more strictly and administrators of hospitals and nursing schools attempt to install in all ranks of nursing service a commitment to giving patients both personal care and emotional support. Therefore the hospital temporarily replaces the family in meeting the patient’s needs (Glaser 1970:110).

In Bangladesh, relatives are almost inseparable actors in the whole process of hospital care. The obvious presence of relatives in the ward has both structural and cultural dimensions. As the hospital is severely under-resourced and understaffed, it is not feasible for a Bangladeshi public hospital to provide all the necessary support to the admitted patients. As a result, the relatives of a Bangladeshi patient do not rely completely on the hospital facilities and take up various responsibilities of patient care themselves. As the hospital staff acknowledge, albeit reluctantly, that they depend on the essential support of the family members of the patient, family members have thus become an integral part of the informal hospital organisation.

There are deep-rooted cultural reasons behind this family involvement as well. Like in many other non-Western countries, social systems in
Bangladesh are mostly based on primary relationships and family is a crucial unit in the society. In most cases, family influences the important decisions of an individual's life concerning issues like selecting a marriage partner, choosing a career, buying property and so on. Abasiekong (1981) discussed how in a non-Western context, in contrast to the individualism in the western societies, 'familism' (the subordination of individual goals and decisions to those of the family) plays a very important role in the day-to-day decisions that people make about present and future plans. As a result, whenever an individual becomes ill, the family members become involved in selecting and organizing the therapy. Janzen (1978) discussed how the management of illness and therapy by close kin is a central aspect of the medical scene in central Africa. He developed the concept of 'therapy management' (diagnosis, selection and evaluation of treatment, as well as support of the sufferer) and 'therapy management group' (the set of individuals who take charge of therapy management with or on behalf of the sufferer). He wrote that 'the therapy management group thus exercises a brokerage function between the sufferer and the specialist' (1978:4). The same is true for the family members in Chittagong Medical College hospital. We have observed how the relatives function as middlemen between the patient and the hospital staff, as well as between other actors outside the hospital. It is also interesting to observe how different patients and relatives help each other by developing fictive familial relations.

Kirkpatrick (1979) showed how hospitalisation is a culturally alien experience for an Indian patient. She observed the unwillingness of families to permit a member to be separated from kin control, care and observation. She quotes Gluckman (1962), whose comment is well applicable for Bangladeshi society:

> People in societies organized mainly through kinship (primary relations) cannot easily segregate the activities of everyday life and the persons associated with these activities from each other to the extent possible in structurally more complex societies. A dire event befalling an individual in the traditional society has wider implications for a greater number of 'significant others' and for strain within the role system than is the case in societies like that of U.S. or those of industrialized Europe. In the latter social roles are more segregated and the range of significant others tend to be restricted (Gluckman in Kirkpatrick 1979:4).

In addition, a number of relatives I spoke to during my research felt that it was their moral duty to attend their sick family member in the hospital. This sense of duty also has a cultural and historical dimension. In his paper comparing the
pattern of elderly care in the Netherlands and South India, Van der Veen (unpublished) discussed the differences in the sense of duty and love towards kin members in between Western Europe and India. He argues that the preference of Dutch families for admitting their elderly members to institutes, in contrast to the Indian practice of caring for the elderly at home, is a logical outcome of the historical process. In the West, the notion of an autonomous individual has contributed to the development of a society in which highly professionalised care is considered a right of every citizen. The decision to fall back on professional caretakers illustrates the idea that not too heavy of claims should be made upon kin; it is openly expressed that too much duty would spoil their children’s love. However, according to the cultural code of Bangladeshi society, love and duty are seen as being inextricable from each other, rather then segmental. Moreover, because of the absence of large-scale systems of social security, dependence on individual persons is inevitable in Bangladeshi context.

For Bangladeshis, their sense of duty is also tied up with the sense of relational obligation and social embarrassment (‘What people will say if I am not beside my brother when he is hospitalised?’). Maloney discussed this aspect of the behaviour of Bangladeshi people in relation to the idea of guilt (1986:64). He observed that in Bangladesh, as in many other Asian societies, the sense of duty is not bound up with the European concept of guilt, which has its roots in the Christian tradition. The Bangla terms for ‘duty’, kartabya and daitya, do not actually carry the meaning of an abstract obligation, rather the implication is usually about the immediate task at hand or the relational obligation. Interestingly, he noticed that Christian churches in Bangladesh have had to modify their teachings about the role of Christ in the life of Christian. His role to remove guilt and bestow forgiveness is less emphasised than in the West; his role as giver of blessing to solve practical problems is emphasised.

Thus, the crucial role of the family members in the ward once again speaks to Bangladeshi society at large. On one hand, it demonstrates the scarcity of manpower in the hospital, which is a result of general poverty of the country, and on the other hand it manifests the deep cultural value of family in Bangladeshi individual’s life. It shows how in the absence of institutional support systems, the family becomes the main organisation of support during crisis. The voices of the relatives also show the value of relational obligation in the Bangladeshi society. Finally, the preponderance of male relatives demonstrates the limited mobility of women in public sphere, as a result of the notion of purdah.