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

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Chapter VIII

NURSES: LADIES WITHOUT LAMPS

'I see you taking notes all the time. What are you writing? I heard that government hospitals will be privatised, are you investigating on that?' One nurse who was filling out a register asked me these questions while I was sitting in the nursing room recording my observations into my field notebook. I assured her that I had nothing to do with privatisation and briefly told her about my research. I then asked her: 'I saw you are also writing since morning. What is this register about?' She explained: 'This is a morning statement, I have to send it to the director's office with the present status of the ward. More writing will start after the round is over; we will have to put all the orders in the file. See all these registers, we need to fill these out too'. She showed me a pile of registers sitting on the table. Another nurse was making cotton balls to be sent for autoclaving.

The nurses' room is situated in the middle of the big open ward. As mentioned before, two sides of the room are covered in glass. As a result, it is possible to view the entire ward from this room. There is a big table in the room; a long bench and three chairs surround the table. There is a rack where the files of the patients are kept. There is also a cupboard in which the instruments are kept. The key to the cupboard is with the nursing supervisor. The dressing trolley is kept in one corner of the room. There is a small resting room with a bed adjacent to this room.

The nursing supervisor, who had accompanied the doctors on the round, entered the room with three other nurses. The other two nurses brought all the files of the patients from their bed to update the orders according to the decisions made during the round. Two of the nurses went into the small resting room. A relative of a patient entered the nurses' room and asked: 'Sister, my mother is crying in pain. Can you please come for a while?' The nurses did not pay any attention to the relative. The relative repeated the question. The nurse who was writing the statements then said passively: 'Go to your bed, I will come when I am done'. She continued filling out the register. The son of the patient came and said: 'My mother is dying of pain and you are gossiping here. Can you imagine how I feel?' The nurse became angry. 'Do not talk nonsense. We are not gossiping here. Why do you come to us, can't you ask the doctors? Now get out of here.' The relative left.

The nurse said to nobody in particular: 'How can we attend the patients when we have to finish writing all these files and registers?' She then turned to me and said: 'If they privatise the hospitals, I hope they will find some people to do this writing and let us do some nursing.' The nursing supervisor then said: 'Okay, leave that and tell me which of you is going for Durga Puja [a
Hindu religious festival] holiday?' Two of the nurses said they would go and asked the supervisor to arrange the schedule so that their Muslim colleagues could replace them. The supervisor herself was Hindu; she said she would also go for the holiday. She brought the duty register and began to find a way to sort the schedule out.

I wanted to know why there were so few Muslim nurses in the hospital. The nurse who was writing the statement told me: ‘You know that Muslim girls are still reluctant to come to this profession. Many think that this is a shameless, immoral profession.’

In this chapter, I will expand on the experiences and concerns of the nurses of the ward. I will describe how the nurse's role has altered in Bangladeshi hospitals, such that they have now become caretakers of administrative papers and equipment, rather than caretakers of patients. I will also discuss the negative social image of nursing in Bangladesh. As in other chapters, a summary and discussion will follow the description.

The white sharis

Nurses are easily recognisable in the ward, as they are the only staff members who wear uniforms. The majority of the nurses are females and they wear white sharis (saris) and a white cap. The male nurses wear white shirts and white trousers. They have different coloured belts around their waist, which reflect their seniority. During my fieldwork, there were 18 nurses attached to the orthopaedic ward. Among the staff nurses, six were male and the remaining twelve were female. Of the six male nurses, two were assistant nurses. In addition to the 18 nurses, there were eight student nurses also assigned to the orthopaedic ward. There were an equal number of male and female student nurses.

**Table 8.1: Staffing pattern of the nurses**

<table>
<thead>
<tr>
<th>Position</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing supervisor</td>
<td>1 (female)</td>
</tr>
<tr>
<td>Staff Nurse</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>(13 female, 2 male)</td>
</tr>
<tr>
<td>Assistant Nurse</td>
<td>2 male</td>
</tr>
<tr>
<td>Student Nurse</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>(4 female, 4 male)</td>
</tr>
</tbody>
</table>
The number of nurses present in the ward fluctuated throughout the day. The highest concentration of nurses was during the morning shift, when about six to eight nurses were present in the ward. The number decreased in the following shifts; in the evening shift, there was an average of four nurses, and by the night shift there were only two nurses. They worked in rotation. Unlike those of doctors, the duties of the nurses are not divided by the unit of the ward. All the duty nurses are supposed to work for all the patients from both units.

The nurses work under multiple bosses. The nursing supervisor distributes the day-to-day work of the different nurses and supervises them as they carry out her orders. Nurses are also answerable to the hospital matron, who occasionally visits the ward. Nurses’ day-to-day medical activities are supervised by the CA. The heads of the two units in the ward also oversee their work.

Most of the nurses are from lower-middle class backgrounds and came from in and around Chittagong, the city in which the hospital is situated. Seven of the eighteen nurses are Muslim, ten are Hindu and one is Christian. It has always been the case that the majority of the nurses in Bangladesh are Hindus because the notion of purdah has prevented Muslim women in Bengal for many years from taking up any profession that will bring them outside the home.

Doctors use the English word ‘sister’ and ‘brother’ to address the nurses. Patients also usually address them as ‘sister’ or ‘brother’ (in English), but some call them ‘nurse’. The nurses, however, call each other by name or apa if they are a female Muslim or didi if they are female Hindu, and vai if they are a male Muslim or dada if they are a male Hindu.

Although I talked with most of the nurses on duty, there were several with whom I had the most interaction. Among them was the nursing supervisor, Gita Rani. She is a composed, cool-headed woman who has been working as a nurse for the last twenty years. She manages the junior nurses efficiently when they come to her to consult with her. She also deals with both doctors and patients quite diplomatically. Hasina, a staff nurse, is relatively junior. She does not seem to be motivated to perform her work. She told me that when she was a young girl, she dreamt of wearing the white shari of the nurses, but now she is disillusioned by the nursing profession and is frequently irritated with the patients. Shantona, a student nurse is a hardworking girl, who tries to learn the nursing ropes as quickly as possible.

Registers, files, forceps

It was interesting to observe that nurses do very little actual nursing in the ward, but instead are mostly busy with a variety of administration and
paperwork. The nurses are required to fill out a number of registers and send reports to the hospital administration. Nurses are busy with the piles of registers kept in their duty room, particularly during the morning shift. The following are the registers maintained by the nurses:

1. Assignment register. In this register the nursing supervisor writes the everyday assignments of the duty nurse.
2. Record register. Contains the identity and diagnosis of the admitted and discharged patients.
3. Handover register. Contains a list of items in the ward (such as sheets, mattresses, and equipment) that the nurses hand over from one shift to another.
4. Round Register. Contains the advice and orders given during the round.
5. Pathology requisition register. Contains a list of pathology tests needed for patients.
6. X-ray requisition register. Contains list of patients who need X-rays.
7. Special attention register. In this register the nurses write notes about certain patients who need special attention from the nurses of the following shift.
8. Register for police cases. Contains the list of patients that are considered to be police cases, such as road traffic accidents or criminal violence.
10. Drug register. Contain the list of available drugs.
11. Register for absconding patients. List of patients who have absconded from the ward.
12. Referral register. Contains the list of patients referred to another department of the hospital
13. Death register. Contains the list of deaths in the ward.

Every morning one nurse is assigned to prepare a report that they call ‘the morning statement’. This report contains the number of patients admitted on that particular day, as well as their diagnosis, and the number of patients discharged the day before. The statement also contains the list of police cases, absconding cases and death cases. To prepare the report, the nurse must consult all of the relevant registers. The nurse makes carbon copies of this statement and sends it to three different offices: the office of the director of the hospital, the Matron’s office and the diet room. The nursing supervisor tries to make sure that the statement is sent off as early as possible each morning. The nurses however, do not actually have a clear idea of the use of this statement. When I asked the supervisor what the office will do with this statement, she said: ‘Who
knows? Maybe they will send it to the ministry. Probably they want to evaluate our work. My job is to send it to the necessary offices; I try to do it in time. That’s all’. It has become an unquestioned ritual. Every morning one nurse starts the day by preparing the statement and the supervisor passes it upward, without being concerned about its implications.

One nurse is responsible for the handover register. The nurses seem very concerned about this register. The assigned nurse takes the handover register from the nurse from the previous shift and she checks each item mentioned on the register one by one. The nurse then tries to keep track of the items during her shift, as she needs to handover all the items to the nurses on the following shift. If any item is missing, the nurse responsible for the handover register is fined for it. In order to help the particular nurse, other nurses on duty also keep eye on the items. In addition to 92 bed sheets and 15 extra mattresses, there are 21 surgical and medical items that the nurses hand over from one shift to another. The surgical and medical items list is as follows:

<table>
<thead>
<tr>
<th>Item</th>
<th>Number</th>
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</thead>
<tbody>
<tr>
<td>1. Artery forceps</td>
<td>5</td>
</tr>
<tr>
<td>2. Needle holder</td>
<td>1</td>
</tr>
<tr>
<td>3. Tooth dissector</td>
<td>1</td>
</tr>
<tr>
<td>4. Lifter</td>
<td>1</td>
</tr>
<tr>
<td>5. Dressing tray (big)</td>
<td>2</td>
</tr>
<tr>
<td>6. Dressing tray (small)</td>
<td>2</td>
</tr>
<tr>
<td>7. Plain scissors</td>
<td>1</td>
</tr>
<tr>
<td>8. Torch light</td>
<td>1</td>
</tr>
<tr>
<td>9. Bandage cutting scissors</td>
<td>1</td>
</tr>
<tr>
<td>10. Kidney tray</td>
<td>1</td>
</tr>
<tr>
<td>11. Scissors tray</td>
<td>1</td>
</tr>
<tr>
<td>12. Oxygen meter</td>
<td>1</td>
</tr>
<tr>
<td>13. Oxygen cylinder</td>
<td>3</td>
</tr>
<tr>
<td>15. Dressing drum</td>
<td>3</td>
</tr>
<tr>
<td>16. Plaster cutting scissors</td>
<td>1</td>
</tr>
<tr>
<td>17. Sucker machine</td>
<td>1</td>
</tr>
<tr>
<td>18. Thermometer</td>
<td>2</td>
</tr>
<tr>
<td>19. Kettle</td>
<td>1</td>
</tr>
<tr>
<td>20. Sterilizer</td>
<td>1</td>
</tr>
<tr>
<td>21. Stethoscope</td>
<td>1</td>
</tr>
</tbody>
</table>

The nurses complain that sometimes the intern doctors forget the forceps, scissors or surgical tray beside the patient’s bed and then the items go missing. They complain that ward boys steal the items. There are also cases when
patients and their attendants have stolen bed sheets when leaving the hospital after being discharged. The nurses must therefore make a big effort to keep an eye on these items.

Once the round is over, the duty doctors add their new advice and treatment orders to the round register, and later on to the patients’ files, based on the discussion during professor’s round. The nurses bring all the files to their room and look for the new orders. They fill out the pathology, X-ray and diet requisition registers according to the orders. They also make separate referral slips for the different tests to give to the patients. They check which medicines are available in the ward and then make another slip of the remaining medicines that the patients need to buy from outside of the hospital. The nursing supervisor sends a requisition order to the hospital medicine store according to the daily requirement of the drugs and sends the ‘medicine boy’ (the ward boy in charge of retrieving the medicines) to fetch them. Nurses also write special attention notes in some of the patients’ registers for the nurses of the following shift. Special attention notes include notes about the time a transfusion of blood or change of saline is necessary. On operation days, they must fill out additional forms for sending the patient to the OT. They need to ensure that all the appropriate investigation papers accompany the operative patients as well. Clearly, a large part of the nurses’ duty time is spent busy with registers, slips, files and reports. The nurses themselves are also frustrated about this.

We should be called as clerks, not nurses. Since morning I have been holding my pen. If all the time I am writing when I am going to look after the patients. I think there should be some separate staff for doing paperwork. (Maloti, staff nurse)

Ten years back we didn’t do so much paperwork. I remember I also had time to feed patients by hand. But now, as the number of patients has increased, they have also increased the amount of paperwork. We do not have time to do nursing work. (Gita, nursing supervisor)

Little touches with the patients

When reflecting on their medical and nursing duties the nurses mentioned the following responsibilities: receiving the patients, recording their vital signs, distributing drugs and monitoring medication, dressing and assisting with dressing wounds, making beds, monitoring patients’ diets, training patients and attendants to do relevant exercises, assisting with operations and providing discharge advice to the patients.
By ‘receiving the patient’ the nurses mean that upon the arrival of a new patient in the ward they put them in a bed, with the help of ward boys. Then they make a file for the new patient by entering the name and address of the patient on a prescribed form. They keep the file on the bed of the patient and wait for the doctor’s orders for medications.

Though they record the vital signs, like pulse, blood pressure and temperature of the patients upon arrival, they do not continue to do so in the following hours. As one nurse mentioned:

Vital signs are not maintained in the orthopaedic ward as they are in the [internal] medicine ward. In the medicine ward, the doctors want to know the vital signs every hour, so that is a must in the medicine ward. But here doctors do not want to know the vital signs regularly. It is not that important for the treatment here, so we do not maintain that. (Amina, staff nurse)

The nurses distribute the medicines that are available in the ward. As mentioned before, only a few of the required drugs are given by the hospital, the rest must be bought from outside by the patients. It is mainly the nurse who supplies the list of drugs that should be bought from outside to the relatives. Nurses tell the patients about the dose of the medicines. However, I did not see the nurse monitor the administration of medication. They just casually ask the patients while passing by the bed, ‘Did you take the medicine in time?’ They do not actually check the medicine intake properly. But they are conscientious about giving injections. They even take some pride in this act injecting, and feel content that at least this is a task that the relatives are not able to perform. Hasina, a staff nurse said: ‘Relatives have taken over all our nursing jobs. But for injections they will have to call us’.

The nurses assist with dressing wounds. Usually the dressing is done by intern doctors and the CA, however nurses also do the dressing themselves, particularly when the patient load is high, and is not manageable by the doctors. In such situations ward boys also do the dressing.

Nurses assist in the operation theatre. They prepare the surgical instruments and operation gowns for the doctors before the operation starts. Nurse also sometimes assist the doctors during the operation by holding a patient in position or by supplying the instruments asked for by the doctor.

In the morning, one of the nurses, usually an assistant or a student nurse, is assigned to bed making. In fact, there is not much to do in bed making. Nurses usually just smooth out the bed sheet before the professor’s round. They do not need to adjust the tractions of patients in the beds. Because it is done in the beginning of the traction, there is no need for the nurse to
adjust it every day. For the patients having traction, the foot end of the bed is usually simply kept high. As one nurse said:

We read lots of things in our book about bed making. For arthritis patients a hard bed, for burn patients a boat-like bed etc., but where would I make all those beds? We even cannot provide beds to all the patients, and put them on the floor. Moreover the beds are age-old, almost broken. So in the name of bed making I just see whether the bed sheet is okay? (Shantona, student nurse)

Monitoring the patients’ diet is also the nurses’ responsibility. One nurse sends the diet indent to the kitchen according to the prescription of the doctors. Communication about the diet is done in code numbers. The following are the codes: Diet-1 is a regular diet from the kitchen; Diet-2 is a high protein diet; Diet-3 is a salt-free diet, mainly for hypertension patients; Diet-4 is sweet-free diet for diabetic patients; Diet-5 is the admission diet, which is a quick meal for the newly admitted patients; and Diet-6 is a liquid-only diet. However, most of these diets are not available. As Bilqis, a staff nurse, told me:

A few years back, patients were given a piece of bread and a glass of milk upon admission, which we called the admission diet. But nowadays, there is no more admission diet. Nor does the kitchen prepare any salt-free or sugar-free meals. So every one is mostly given Diet-1, the normal diet, or sometimes the liquid diet. Sometimes however, we give an indent for a high protein diet, and the patient is supplied with just an extra egg.

Nurses sometimes train the patients or their attendants to perform the exercises that are indicated by the doctors. In addition it is usually the nurse who communicates the discharge advice to the patients.

‘We are left alone to handle the public’

The English word ‘public’ is frequently used in Bangla to refer an undisciplined crowd. The nurses used the word ‘public’ to refer to the patients and their relatives in the ward. They felt that they are the one who are mostly forced to deal with the public. The doctors are socially far-removed from the patients, the lower staff are not equipped to answer the medical queries of the patients, and as a result it is the nurses to whom the patients approach with all of their demands. The nurses have the most difficult time handling the ‘public’ during the evening and night shifts, when only a few junior doctors are present in the ward. As one nurse said:
In the morning the patients are afraid to ask questions to the doctors, when the doctors leave, the patients rush to us with all sorts of questions. They want to show us their X-rays, their blood reports and so on. Sometimes, in the evening or night shift, there is no doctor to call or to consult, maybe one or two intern doctors who are also busy with some other work. We are then left alone to handle the public.

They find it difficult to handle the public as they also think like the doctors, that patients and relatives ask unnecessary questions. Sometimes stupid demands make them angry. One nurse told me:

One patient just told me that the capsules were not working; I should give him injections because injections are stronger. Another day one patient asked me why I am giving him such a small tablet, while the patient to his next bed getting bigger tablets? How can you keep your temper cool with these demands?

Another nurse told me:

Bed number 83 offered me money and requested an antibiotic injection from the hospital. I repeatedly told him that there is no injection supply from the hospital. But he did not believe me and kept on requesting one.

Some nurses expressed their distaste for this public nature of their nursing job. As Anita, a staff nurse, said:

In nursing you always have to deal with the public. I hate to deal with the public. This is risky, because the public becomes very ferocious if their demands are not satisfied. It would be better if I would be a schoolteacher, then I would not have to face the public like this. Here I have to mix (mela mesha) with hundreds of different people, while a teacher only meets with her students and the colleagues. That profession also has honour (izzat) in the society.

Nurses developed various strategies to avoid the unruly public. Most of the time they responded to the indiscipline in the ward by withdrawing to their duty room, and ignoring the questions and demands of the patients or their relatives. However, they also are aware of not generating conflict with the public. As one nurse said:
The relatives come with all kinds of requests: ‘Sister could you please check the saline drip, it seems very slow’ or ‘Sister, my patient is having severe pain, please come for a while’. Most of the time these are false complaints, I therefore try to avoid them, but I can sense when they (relatives) are losing their patience. Then I pay a visit to the patient’s bed just to console them.

There were, however, nurses who had learned by bitter experience ‘how to speak’ to avoid the trouble which pertained when ‘the public’ became angry. During some troubled situations nurses usually do not get heated and avoid the confrontation by remaining silent or withdrawing from the scene, unlike doctors or ward boys or cleaners, who would overshadow the anger of the public by shouting and scolding. This attitude, however, is observed only with the female nurses; it is definitely an issue of gender. The female nurses felt that they would not be able to control the male relatives because relatives expect them to conform to the normal gendered role of a woman and not to be too outspoken.

I do not go to fight with the people. This is a male dominated society (purush shashito somaj). They think: ‘Why should I listen to a woman, what does a woman know (meyloke ki jane)?

Doctors are the boss, but...

According to hospital hierarchy, nurses are subordinate to doctors. Doctors give orders and the nurses carry them out. But because of the different lines of authority, doctors cannot take disciplinary actions if nurses fail to carry out their orders. The nurses are accountable to the matron and the hospital director, not the doctor. However, the matron and director depend on doctors’ comments and reports about nurses’ performances to evaluate them, so there is some degree of influence on the part of the doctors. Nurses generally act submissively to doctors, although their degree of deference varies according to the rank of the doctor. It is common to see the professor scolding the nurses for their mistakes. The nurses usually remain silent during the lecture, but sometimes they make jokes afterwards about the scolding if they realize that the mistake was not their own. We may recall the reaction of the nurse in the opening scene of Chapter One, in which the professor scolded the staff for missing scissors.

However, similar tolerance is not shown by nurses towards junior doctors, and particularly not towards the intern doctors. Nurses sometimes ignore the orders given by intern doctors. Sometimes they even accuse intern
doctors of delaying treatment orders. Once a senior staff nurse told an intern doctor:

I have received this patient at 1:00 PM, and I made the file. It is now 7:00 PM and none of you have seen the patient. The patient is annoyed with me. You cause delays and the patient is angry with us!

In another incident, a staff nurse gave an antibiotic injection to a newly admitted patient before the intern doctor had checked the patient. The duty intern doctor was annoyed and said: ‘Why did you give injection to the patient without asking me?’ The nurse replied: ‘How long should I wait? None of you were coming. I knew this patient needed an antibiotic injection immediately. I have been working here for five years.’

On several other occasions similar conflicts between experience and authority emerged. Once an intern doctor told me that it is difficult to get things done by nurses. ‘They tend to ignore intern doctors orders. As if we are still students. I need to ask the nurse thrice to get me forceps.’

Coser rightly pointed out the centre of the problem. ‘[B]oth have ‘not quite’ that status they envision for themselves, the nurse is ‘not quite’ authority holder over the ward and the intern is a ‘not quite’ a physician’ (1962:24).

There have also been incidences of more serious disputes between doctors and nurses. Before I started my fieldwork, a medical officer from the other unit slapped a nurse because of a mistake she made. This generated serious resentment among the nurses. All the nurses of the hospital went on strike in protest of the doctor’s act. They demanded termination of that doctor. An inquiry committee was formed. The doctor was transferred to another department. The nurses returned to work after a week.

Nurses feel that doctors do not acknowledge the crucial support they provide to them:

We have all the information about each patient; doctors always need to ask us for information about the ward. As we do the paperwork, we have a complete picture of the ward. Ask the doctor, they will not be able to tell you many things. If we would not prepare the patients for OT properly, and would not ensure the tests and medicines, the doctors would not be able to work. But they do not want to give us merit. They think we are deceitful (fakibaj).

Nevertheless, nurses also have friendly encounters with doctors. Though I have never seen a nurse sit in the doctors’ room, doctors often come to nurses’ room for friendly chats with them. There are also stories of romantic affairs and marriages between doctors and nurses, though because of the unequal social
status, this is not very common. I did not encounter any such relationship between a doctor and nurse in this ward, but joking comments were not uncommon. After the CA scolded two student nurses, the nursing supervisor said to him: ‘You are too rude to girls. You need some softness in your heart. Have an affair and get married. You will learn how to talk with girls.’

Not a glamour girl

Although some nurses joined the profession with the motivation to help people, for majority the motivation was economic. The following comments give the personal background of some of the nurses:

I have five sisters but no brother. My father used to have a small job. It was difficult for him to maintain the family. As the eldest daughter, I decided that I would earn money and help my father. My father didn’t have the ability to provide me with a higher education. In our time there were not many jobs for women. Nursing was the best option. (Gita, nursing supervisor)

One of my aunts was a nurse. I used to come to hospital with her. I was very impressed by their white dress. I had a dream that one day I will wear this. My family was not economically stable, so I also wanted to be economically independent. I did not have much higher education, so I took nursing. (Hasina, staff nurse)

Two years after my wedding my husband died. I had to find a job to survive with my little one-year-old boy. Nursing was suitable with the qualifications I had. Moreover, I once wanted to join missionary and become a nun. Nursing gave me the opportunity to fulfil the duty of god. It also helped me to survive economically. (Rosalin, staff nurse).

Some nurses told me that many widows and destitute women joined nursing as it gave them a good social and economic base. However, although their economic objectives were fulfilled after starting a career as a nurse, most of the nurses are unhappy because of the social image of the nursing profession in Bangladesh. They felt that they are not respected by the people as other professionals with similar qualifications are. This is, however, not the view of the few male nurses. The female nurses mentioned a number of causes behind this disregard for the nursing profession.

First, nurses felt that people think nursing is an immoral profession, particularly because they stay in the hospital at night with doctors and other males:
People think that our work is not decent. We do night duties. It is bad for a Muslim woman to stay outside her home at night. They think nurses have illicit relationships with doctors or other males. As a result nurses face trouble in getting married. One of my fellow nurses had an affair with a doctor and they got married. But the doctor’s family rejected them. His family did not come to the wedding. The doctor’s family thought that it was a shame for the doctor to marry a nurse. (Hasina, staff nurse)

Secondly, the nurses felt that people look down upon them because many girls from poor families come to this profession and the work that they do is considered dirty.

One of our colleagues went to London for a special nursing training. She saw there that rich, educated girls become nurses, so they are honoured. Here people think: ‘Oh, these girls are from poor families, they earn money by doing dirty jobs’. Moreover, in our religion people also associate us with lower caste as they think that we do dirty jobs. So people do not value nurses (dam die na). (Sobita, staff nurse)

Finally, they also suggested that the fact that the people did not give any value to nurses was because the doctors and other higher authority did not value them.

Doctors always scold us in front of people. When the superintendent comes to inspect our work, he also shouts at us in front of everybody. How then will the people give us value? (Bilkis, staff nurse)

Summary and discussion

Most of nurse’s duty time is spent on paperwork, such that they can hardly do any nursing or medical work. The nurses are preoccupied with reports, registers and files. They maintain thirteen registers and prepare a number of reports. They are the custodians of the administrative records and the equipment of the ward. Shift after shift, the equipment and supplies listed in the registers are checked, counted and handed over. Daily completion of the bed statement, pathology and X-ray forms, discharge forms, day and night order books and stock and diet registers are maintained.

The medical work that nurses do is very little. Nurses usually do not assist patients in their day-to-day activities in the ward; these tasks are generally taken care of by the attendants of the patients. Nurses do not provide
any emotional support to the patients, either. It appears that nurses are mainly
the caretakers of papers and registers, rather than the caretakers of patients.
Their medical tasks include distributing drugs, giving injections and assisting
doctors in dressing wounds and during operations. In addition, the nurses have
brief encounters with the patients while receiving them after admission,
recording vital signs, making beds, monitoring patients’ diets and training the
patients and attendants to do relevant exercises.

Nursing emerged as a profession around the end of the eighteenth
century. Credit for the respectability of the profession largely goes to the effort
of Florence Nightingale (1820-1910). With her endeavours in the Crimean War
(1853-1856) and her ideas about nursing, it started to become a respectable
occupation for women. She developed the image of a nurse as ‘the lady with
the lamp’, a noble, motivated, loving, self-sacrificing and untiring woman. In
later years, when institutes for training nurses emerged, they also trained nurses
into fulfilling such an image. As Ehrenreich and English wrote:

The finished product, the Nightingale nurse, was simply the ideal
Lady, transplanted from home to the hospital, and absolved of
reproductive responsibilities. To the doctor, she brought the wifely
virtue of absolute obedience. To the patient, she brought the selfless

Coser similarly referred to the nurses of the Mount Harmon hospital in the
United States as ‘quasi-mother figures’. She wrote:

The English term ‘sister’ (like the German ‘Schwester’ and the French
‘soeur’) suggests a personal closeness in the nurse-patient relationship.
In a similar vein, the expressions “nursing the sick” and “nursing the
baby” denote at least a metaphorical similarity between care of
the patient and nurture of the child. The emphasis is upon protection and
emotional gratification (Coser 1962:70).

By reviewing the role of nurses in Britain in last few decades, Armstrong
suggested that in contrast to doctors, nurses in Britain have succeeded in taking
their role for care beyond only the biological functioning of the patients. He
wrote:

Certainly the doctor with the technological devices and interests in
biochemical pathways has often seemed in danger of relating to the
patient only as a biological object; but in contrast, the nurse, through
being constantly by the patient’s side and caring for the patient’s basic
functions, has of rights a special relationship (Armstrong 1983:457).
Bearwood et al. (1999) wrote about how nurses in Canada have restructured their profession according to the formal complaints of patients against them, and made it more patient friendly.

However, these images of nurses in Western countries do not fit with the image of Bangladeshi nurses. Because of the various local factors, the typical role of the nurse is much altered here. Nurses in Bangladesh are situated in such a position that it is not possible, either socially or structurally, to relate them to the Nightingale's 'lady with lamp' image. The metaphorical similarity of 'nursing the sick' and 'nursing the baby' is also absent in this context. 'Shebika' is the Bangla word for nurse. It suggests personal closeness, but is never used nowadays; there is no 'special relationship' between nurse and patient. Moreover, the nurse to patient ratio is so low that it is not possible for them to take care of all the admitted patients. It is also impossible for the nurses to show any mother-like devotion with so little resources supplied by the hospital.

Karmakar (1993) discussed how the first senior nursing school, headed by a British matron, was established in Dhaka, now the capital of Bangladesh, in only 1947. After the partition of India and Pakistan, only 50 nurses from India opted to come to what was then East Pakistan. Of these, eight were sent to London for higher nursing training in 1949. After their return, most of these nurses took up the leadership position in developing nursing services in the country. The first nursing college was established in 1970. After the independence of Bangladesh, a number of undergraduate and post-graduate nursing institutes increased, and a separate Directorate of Nursing Services was established. However, although the volume of nursing professional increased in Bangladesh, the core value and the character of the profession has been lost.

When the bureaucratisation of hospitals began in the first half of the twentieth century mainly in the Western countries, nurses took on some new functions, including administrative and clerical responsibilities, in addition to their nursing job (Simpson et al. 1979). But in Bangladesh, it appears that due to a lack of administrative manpower, nurses have almost entirely absorbed themselves in paperwork, and nearly abandoned the nursing part of their work. This altered definition of a nurse's role gives them the opportunity to avoid getting too close to the complaining patients and dissatisfied relatives. Bangladeshi nurses' work does not fit with what Van Dongen and Elema wrote while discussing the 'body work' of nursing.

Touching in the nursing is inevitable, because the patients are dependent on nurses for many activities in daily living: washing, feeding, lifting, dressing. (Van Dongen & Elema 2001:156).
Nurses in Bangladesh hardly touch the patient; the relatives of the patients do all the ‘body work’ and play the role of nurses. Karmakar (1993) similarly observed little nursing work by nurses in another Bangladeshi teaching hospital. The protection and emotional gratification of patients is also achieved by relatives and not by nurses.

Moreover, nurses here are also not the agents of socialisation of patients or the mediator between physician and patients as they are in Western hospitals. Sometimes Bangladeshi nurses act as a mediator by simply repeating a doctor’s advice and explanations. It is rare to see a Bangladeshi patient trying to engage a nurse in conversation for social pleasure.

Sciortino (1992) observed a similarly altered role of nurses in Indonesia. She pointed out that in the rural health centres of Indonesia, there is a discrepancy between the formal and actual role of nurses. Instead of providing nursing care, the nurses in rural Indonesia mainly perform curative tasks. Because of the unavailability of doctors and other administrative constraints, they had to give up their nursing duties and take over the responsibility of providing treatment to the patients. Sciortino wrote that in Indonesia: ‘Nurses are neither doing what they are formally supposed to do, nor what they have been taught to do’ (1992:289). Digby and Sweet (2002) similarly observed changed role of nurses in South Africa, where the biomedical nurses acted as a cultural brokers for traditional medicine.

The worries and concerns that Bangladeshi nurses have regarding their profession also vary greatly from their Western counterparts. For example, Coser (1962:28) wrote that the source of frustration of American nurses is ‘...the problem of “always” having to “clean up after the doctors”, i.e. doing the doctors’ dirty work’. This is not a problem for Bangladeshi nurses, as they can delegate as much of the ‘dirty work’ to ward boys and cleaners as they would like. The major source of disappointment for nurses in Bangladesh concerns their social image. Nursing does not have an image of noble work in Bangladesh. Although Bangladeshi women have been in the nursing profession for several decades (Hussain 1958), they still do not have a respectable public image. Begum (1993) found that more than 80 percent of the 208 students of the only college of nursing in Bangladesh expressed their dissatisfaction regarding their low social status. The low social status firstly comes from the fact that most of the nurses come from lower socio-economic background. As in my study, Begum (1993) found that majority of the nurses come from poor, agriculture-based family backgrounds. Many of the nurses are widows and destitute women who have low social status. In professional settings, the doctors consider nurses as inferiors (Nahar 1991).

The negative evaluation of nursing also comes from the existing religious notions in Bangladesh. The nursing profession is considered socially low because of Hindu ideas about the caste system and because of Islamic
notions about decent moral conduct for women. The Hindu caste system is built on the underlying religious principle of the opposition of the pure and the impure and hierarchy is the ‘superiority of the pure to the impure’ (Dumont 1980). The kind of ‘dirty work’ done by nurses is usually associated with lower caste people. Kirkpatrick (1979) discussed how in India, nursing is socially stigmatised. Bangladeshi Hindu nurses also expressed their concern in this regard. For the Muslim nurses, it is the public nature of their work, their mixing with men and staying outside home during the night is considered morally demeaning. One nurse mentioned how the family of a doctor felt degraded when their son married a nurse. Harun and Banu (1991) discussed how Muslim women of Bangladesh were reluctant to enter into the nursing profession during colonial and Pakistan period. Similar situations are found in some other Muslim Middle Eastern countries as well. El-Sanabary (1996), who studied the social image of nurses in Saudi Arabia and other Middle Eastern countries, found that negative image of nurses in those countries are similarly associated with the intermingling of the sexes that obstructs the principal of gender segregation and is generally believed to lead to immoral behaviour such as illicit relationships. She writes:

Contrary to Western literature that associates nursing with such characteristics as virtue and purity, the taint of immorality associated with nursing in Saudi Arabia and some other Arab countries is the most damaging to the profession and the peace of mind of women who want to peruse it (El-Sanabary 1996:78).

This chapter has shown that the role, image and concerns of the Bangladeshi nurses have gone far and became different from the ideal image of nursing and from the ways it is practised in other parts of the world. They are not sacrificing, respectful ladies with lamps; rather they are irritated, frustrated women running with files and registers. This altered role of nurses tells us about the general scarcity of manpower in a resource poor country like Bangladesh. On the other hand, the negative image of nursing profession tells us about the societal value concerning women’s morality and status hierarchy. It shows that Bangladeshi society generally upholds the notion of female seclusion and attaches lesser prestige to manual labour.