Chapter IX

DOCTORS: PRIDE AND PREJUDICE

We,
Medical College we read,
Anatomy, pathology, medicine surgery,
More names there to which we pay heed,
Medical college we read.
Cardiology, haematology, physiology
Some we understand, some not easy
In medical college we're busy.
We repair bones, sew skin, cut the dead
We are expert heads,
Disease and ailments we make fled.
Dead body we dig, cut and join
Bifurcate belly, dissect intestine,
Knife and scissors, company for our lifetime.
We break the pride of god of death, yet we boast always.
We study in medical college.

This is a translation of a song sang in Bengali by the medical students during a musical night at the medical college. It captures the contradictions and ironies of a doctor’s profession. When students become doctors, they also carry this pride of being ‘expert heads’. The hospital is the place where the doctors demonstrate their pride, authority and power. The hospital is the kingdom in which they are the monarchs.

When I first started my fieldwork, the doctors of the hospital were discussing a strike to protest an assault on a prominent local doctor who was attacked and robbed by some thugs in his practising chamber. I attended the meeting of the doctors in favour of the strike. The speaker was shouting into the microphone: ‘We are protesting against the negligence of the state authority to protect members of an honourable profession. It is a matter of the prestige of the medical profession’. While in the group setting, they seemed confident. However, when I chatted backstage with these proud, self-assured doctors, I found that they were full of various disappointments and frustrations. They did eventually strike, and by the end of the two-week strike, the ward was full of foul smells due to unchanged dressings and infected wounds of the patients. Some half-cured patients had begun to leave the hospital, while other had died.
Doctors’ paradoxical situation with the sense of hierarchy, pride, frustration and insensitivity will be revealed in this chapter

The doctors on duty

I previously mentioned that the orthopaedic ward is divided into two units, and that each unit has a separate team of doctors. I focused my fieldwork on Unit Two. The following are the doctors working in Unit Two:

The Associate Professor. Dr. Hamid Ali is the head of the unit. Though he is an associate professor, everyone in the ward refers to him as a professor. His responsibilities include the medical supervision of the patients, performing operations, training the junior doctors, teaching medical students and co-ordinating the overall activities of the ward. He has published books on orthopaedic issues and is the editor of an orthopaedic newsletter. He is politically active in the politics of the Bangladesh Medical Association (BMA).

The Assistant Professor. Dr. Bazlur Rahman assists the professor in the medical supervision of the patients, in training the junior doctors and in teaching medical students. He also conducts operations. He does not have any administrative responsibilities. He joined the ward a few months ago, when he transferred from a different hospital in an adjacent district. During my fieldwork he was still adapting to the new place.

The Casualty Medical Officers. There are two casualty medical officers in this unit, Dr. Harunor Rashid and Dr. Mahmudul Haque. Their main responsibilities are providing treatment to ‘indoor’ and ‘outdoor’ patients, conducting operations and supervising the activities of the nurses and ward boys. They do not have any teaching responsibilities. Dr. Harunor Rashid has been working in the ward for many years. Dr. Mahmudul Haque has recently joined the ward, after completing a course in skin and venereal disease. As there was no post in the skin and venereal disease department, he was assigned to this ward. He was struggling to learn orthopaedic techniques.

The Register. Dr. Farid Ahmed’s main responsibility is teaching the medical students. He also conducts operations and takes part in the medical supervision of the patients.

The Assistant Register. This post was formerly known as the Clinical Assistant (CA). Staff in the ward still refer to Dr. Shakil Ahmed, who is the assistant register, as a CA. The CA is a training post for doctors who want to pursue a post-graduate degree, i.e. further specialise. The CA trains for two years under the supervision of the head of the unit. The CA in this unit was in his last year of training. He is the busiest doctor of the ward. He takes part in all treatment-related activities in the ward, conducts operations and supervises day-to-day clinical activities. He also supervises the activities of nurses, intern doctors, ward boys and other lower staff. As mentioned before, he belongs to a
particular Islamic religious group called *Tablig*. Unlike other doctors, he always wears the *kurta*, male Islamic dress, and is conscientious about praying regularly.

The Intern Doctors. There are four to five intern doctors in the ward on average. Their training in the orthopaedic department lasts for four weeks, and is part of their one-year internship training. As a result, every month new intern doctors arrive in the ward. They are the most regularly present doctors in the ward. Even if other doctors are absent, it is always possible to find one or two intern doctors in the ward at any time of the day. After a patient is admitted to the ward, it is the intern doctors who give the initial treatment. They put dressings on the patients, assist in operations and do whatever the professor or the CA asks of them.

Although there are a considerable number of female doctors in the hospital, there were no female doctors regularly on the orthopaedic ward. A few female interns did their four-week duty there as part of their training. This striking absence of females could be because doctors consider surgery to be a male job. This is particularly true for orthopaedic surgery, as it demands lots of physical strength. One female intern doctor said:

> Orthopaedic surgery needs lot of bodily strength. I think as a female it is a problem for me. It is not easy for me to do a closed reduction of a big man. Moreover, applying plasters and drilling bone is labour-intensive work. You will not see female orthopaedic surgeons.

The presence of doctors in the ward varies greatly, depending on the time of day. In the early morning, I was sure to find at least one intern doctor and the CA in the ward. In the morning, before the professor comes, the CA does a pre-round with the duty intern doctors during which he prepares for the professor’s round by, for example, making sure all the files are in position and checking which cases need to be discussed with the professor. By 9:30 AM the rest of the doctors arrive, including the assistant professor, register and the casualty medical officers. As the CA always has the most up-to-date information about the ward, they discuss the latest developments on the ward with him. The professor generally arrives around 10:30 in the morning and starts his daily round, throughout which all the doctors present follow him. They discuss the cases and take instructions from the professor.

**The round: Climax of the drama**

The most important moment of the day’s routine is the doctors’ round. If we consider the ward setting as a stage where a play named ‘Patient Care’ is being performed, then the round of the doctors is the climax of the drama. In that
scene, the professor is the main actor and junior doctors and nurses are the supporting actors while the patients seem to be the viewers of the drama.

The whole morning shift, both before and after the professor’s round, is a time of high alert for the ward. All the doctors are present at this hour, and they make sure that everything in the ward runs according to how they see fit. They want every patient to lie in their respective beds. They do not want any outsider present, except for those who have already received permission. One day I was observing a young intern who joined the ward just the day before. He was shouting to a relative of a patient as he was preparing the ward for the professor’s round: ‘Get out at once!’ The relative said: ‘Do not talk like that with me, I am a university student.’ The intern replied: ‘I don’t care. You just get out. This is a place only for doctors and medical students.’ The relative went out. The intern then turned to me with annoyance. ‘Who are you? Why you are still in the ward?’ He had not seen me before. Another intern on duty quickly went to him and explained what I was doing there. The tone of the agitated doctor changed completely. He apologised: ‘I am extremely sorry. I did not know. Please do not mind. You know better how outsiders can be disturbing during the round.’

During this period of the day, the doctors shout, scold, talk and walk freely around the ward, while everyone else, (the patients, other staff and some relatives) remains either still and silent or, if they must talk or move, they do so with great caution. During the round itself, however, it is mainly the professor who talks, while the rest of the staff members remain silent and only answer professor’s questions. If they need to talk among themselves they whisper in one another’s ear.

When the professor starts his round, he acts dissatisfied and angry about everything. He is often angry with the patients for various reasons. Once he found that a patient did not carry out a particular leg exercise that he had been advised to do. The professor vigorously scolded him and told him to keep his leg lifted while lying in bed as a punishment. The patient could not keep the leg lifted for long and dropped it. The professor in another corner of the ward noticed and scolded him. Once the wife of a patient left her high heel sandals beside his husband’s bed when she went out of the ward because of the professor’s round. The professor suddenly noticed the pair of sandals under the patient’s bed and started scolding him: ‘Have you started wearing ladies sandals? Why these things are here?’ After he scolded the patient, he scolded the ward boys for not clearing up the ward properly before he came. When a baby urinated on the floor of the women’s section of the ward, the mother received a vigorous scolding from the professor. One day, the two policemen who were guarding a prisoner patient remained seated in their stools while the professor was on his round. The medical officer went to them and said: ‘You
should have some honour for the professor. You should not remain seated while he is doing the round.’ The two policemen arose from their stools.

The professor is particularly angry with the doctors. The main purpose of the round is to follow up the patients’ conditions and decide which treatment plan is most appropriate, but the round is also a way of teaching the interns. The professor is often dissatisfied with the doctors’ lack of orthopaedic knowledge and their medical performance in general. He poses various clinical questions to the doctors and frequently becomes angry when they fail to give the correct answer. To one intern who was holding an X-ray, the professor said:

‘You don’t know how to hold an X-ray. You made the patient upside down. You always should keep the X-ray in the anatomically correct position. Now tell me whether it is a benign or malignant cyst.’
The intern: ‘Probably malignant’.
The professor: ‘What do you mean probably? I am not doing a probability test here. It is clear in appearance. What is the difference in appearance between a benign and malignant cystic?’
The intern remained silent. The professor then said: ‘It is clearly a benign cystic, see the margins, it is uniform, and not sclerotic. Now, you cannot even differentiate it. How did you pass the exam? How do you expect to carry on your duty in an orthopaedic ward? Want to be a doctor without knowing anything? Just want to put “Dr.” in front of your name, earn money and marry a beautiful girl?’

The scolding continued for quite some time. The professor seemed particularly irritated by the performance of the CA, who is training under him.

The professor asked the CA: ‘Did you check this patient before I come?’
The CA: ‘Yes, sir’.
‘Did you know that you need a lateral X-ray of this patient?’
‘Yes, sir I know’.
‘Don’t talk like politicians. They always say that they know everything and don’t do anything. Where is the lateral X-ray? Do I have to tell you everything in advance? Can’t you make this simple decision by yourself?’
The CA remained silent. The professor said: ‘Now tell me what should be done next?’
The CA replied: ‘We have to do an open reduction’. The CA asked the patient: ‘Did you bring the iron rods?’
Before the patient could reply, the professor said: ‘Stop this rod business. Want to be a big surgeon? It is not a big credit to open the
bone and fix a rod. Have you seen the hand functions? If the hand functions are not OK, what is the use of putting a rod? Then you will make the patient crippled. The family will come to beat you. All your heroism from surgery will be gone’.

The professor suddenly started criticizing the CA’s appearance. He said: ‘Why are you wearing sandals? You cannot become a surgeon wearing sandals. A surgeon should wear shoes’.

As I mentioned before, the CA is a religious person. He takes his shoes off to wash before his prayer. He simply forgot to put them on before the round.

**Nasta: A ritual for group solidarity**

Once the round is over, the doctors go to their respective rooms to have a *nasta*. *Nasta* is a break during which tea and snacks are served. It often marks the conclusion of work. It is usually served every day after the round or after the completion of the operations on the OT days. After the round, the doctors return to their respective rooms. The senior doctors usually follow the professor to his room, and the junior doctors, including the CA and the intern doctors go to a separate doctors’ room. Sometimes the casualty medical officers also join. Once they are all seated, the ward boy/gatekeeper on duty serves the *nasta*, which includes tea and *shamucha* (local snacks) in both the rooms. Buying and serving the snacks is an additional duty of the ward boy/gatekeeper. He buys the goodies with money from a special fund made with contributions of the doctors.

*Nasta* is a ritual. It is a means of sustaining bodily energy and a reward for the toil of work. But it is also an expression of group solidarity. During the *nasta* doctors are among other doctors, there is no public to demonstrate power or authority to.

**In the professor’s room**

The professor has a separate large room. The room is fully carpeted and the windows and the door have curtains. A private toilet adjoins the room. There is a big table in the room, and two rows of chairs in front of the professor’s desk.

Chairs in Bangladesh have a symbolic value, as they do in many parts of the world. The type of chair or stool is symbolic of the status and authority of the person who sits there. Subordinates do not sit in front of a standing senior. Some subordinates even rise from their chair when speaking on the telephone to a senior. Ward boys and gatekeepers are given stools to sit on, but never a chair. In the professor’s room, the chairs of the first row have armrests, while the chairs in the back row do not. The professor’s chair is special, with a
high back. Senior doctors usually sit in the front row in the chair with armrests. If the CA, Shakil Ahmed, comes to the room he usually sits in the back row. Sometimes nurses come into the professor’s room, but they never sit down when in there. Despite my status as a junior doctor, as a guest and a student of an overseas university, I had the privilege of sitting in the professor’s room in one of the chairs with armrests in the front row.

During this time, they talk about issues that concern them, they joke and they learn from each other. They share their problems. The following are some excerpts of the doctor-doctor interaction during the *nasta* time in the professor’s room.

The professor jokingly asked me: ‘Are you also taking note how I scold everyone?’ I said, ‘Should I, sir?’ Other doctors laughed. The professor said: ‘Why not, if that helps you. But take note that we also do good for the patients.’

The professor and other doctors talked about a newspaper report on the only orthopaedic hospital in Dhaka, which gave a very negative picture of the hospital.

The assistant professor said: ‘There is some truth in it.’ The professor: ‘Yes, but to write about medical institutions, one should have at least some idea about certain medical issues. Journalists make stupid comments on medical issues that they do not know anything about. Journalists are happy to condemn doctors. The journalists almost sent me to jail.’

He looked at me. ‘Hope you know Parveen’s case?’

I said: ‘Yes, that news was in all national newspapers.’

He was referring to the death of a 10 year-old girl named Parveen, which was highly publicised in the newspapers a few months before I started my fieldwork. There was an earthquake in the city, and one building collapsed. Parveen was alive when she was rescued from the wreckage, and was taken to the hospital. It was 1:00 AM on admission day for Unit Two. The girl was in a very critical condition, and the duty medical officer tried his best to save the life of the girl. A big crowd that had gathered in the ward demanded that the professor come. The medical officer called the professor at home and discussed the case with him. In the meantime, Parveen died. The crowd became very emotional and angry that the professor had not come. They broke the windows of the ward. The next day there were reports in the newspapers condemning the professor for being negligent. There was a
national-level inquiry into this case. The professor was found not guilty and was cleared of all charges.

The professor said: ‘In the cases of such crush injuries, when the fallen objects are lifted from the body, the patient might look better for a brief period but then suddenly all systems collapse. I discussed everything with the duty doctor over telephone. I knew there was no way this girl could survive. If I would come and the patient died in my presence the crowd would have become more angry and would have beat me up there.’

I asked: ‘Was there any way that the girl’s life could be saved?’.

The professor said: ‘Yes, if we could have given an endotrachial effusion immediately, she could be saved. But we don’t have that facility. I could do nothing by coming to the hospital at that time of night from another corner of the city, but watch her die. All these half-educated journalists who turned to journalism because they failed in all other jobs, wrote that I was irresponsible, negligent and so on. They do not have the slightest idea about clinical issues and have no idea about hospital functioning, but they have their big pens to write about doctors. If you want to write about doctors, you should be aware about some technical issues.’

One day a medical student came into the professor’s office with his mother. The student’s mother had some orthopaedic problems with her leg, which she wanted to discuss with the professor. The student showed the X-ray of her mother that she had made in an outside laboratory. They discussed the case. The professor was polite to the student’s mother and gave her some advice.

The CA Shakil Ahmed came to the professor’s room and said: ‘Sir, I need to take the prisoner patient to OT for dressing. I asked the police to open his leg cuff but the police said I should give him a written request about this. Should I write that?’

The professor said: ‘Be careful about these cases. There was an incident at the Dhaka Medical College, when a police opened the leg cuff of a prisoner with a doctor’s permission. The prisoner then escaped the hospital and murdered someone. The duty police escaped the charge against him because he showed the doctor’s written permission and the doctor was later charged. So be very careful. Try to do the dressing with the cuffs on. If that is not possible keep both the policemen standing in front of the OT door. Learn how to keep yourself safe.’
The professor usually stays in his room for about an hour after the round and then leaves the hospital. Sometimes he spends time with colleagues from other departments, and then goes back to his residence. In the afternoons, he works at his own private practice.

**Junior doctors’ room**

The room of the casualty medical officers, where the junior doctors gather after the round, is not as well organized or as well maintained as the professor’s. There is no carpet and no curtains. There is a big table and a number of chairs around it, but some of the chairs are in need of repair. They too have their own separate toilet, which is very clean, and has a separate bucket for spare water, soap and a towel. This toilet is always locked. The CA keeps the key; only doctors are allowed to use the toilet.

After the round, it is mainly the CA and the intern doctors who sit in this room, have *nasta* and fill out different forms and papers. They change treatment plans, write letters of discharge and operation notes based on the decisions made during the professor’s round. The assistant professor and the casualty medical officers join them for a while after finishing tea with the professor. While they take *nasta* and do paperwork, they gossip about all sorts of things. Some excerpts of conversations:

The CA said to the casualty medical officer: ‘The professor should stop scolding me like this in front of the patients. This is insulting.’
The medical officer replied: ‘Everyone knows that our professor is *hyper* [a term used to indicate excessiveness of any medical condition] about everything. You are here for more than a year. I thought you would be used to it by this time.’
The CA: ‘Yes I am but you see, in front of the patients, this is sometimes too much.’
The medical officer: ‘Patients know that he is the big doctor, so he has the right to scold everyone. Don’t worry, just follow what he says, you need a certificate from him, don’t you?’

An intern doctor: ‘Boss [they call the CA ‘boss’ in a friendly manner], my mother says as soon as my intern duty started, I became a machine. My relatives come home and never can see me.’
The CA: ‘Yes, doctors are surely machines. Now you are a manual machine. After some years you will be an automatic machine like me.’
One intern said: 'Let the professor say what he wants, but I believe the leaves the bonesetters use actually work. I have seen patients to get cured.'

Another intern: 'You cannot say this after studying medicine for five years. Boss, what do you say?'

The CA: 'Well I am a believer, I believe in Allah. Allah must have kept remedies to our problems in nature. For simple cases it might work, but the bone setters try to treat all cases.'

One casualty medical officer: 'The professor said that we [the casualty medical officers] should put our home telephone numbers on the notice board.'

The other casualty medical officer: 'I am not going to do it. The notice board is open to the patients and their attendants as well. No use of making my telephone number available to all of them. They will make my life hell. They will start doing PR on me.' [PR is short for *per rectal*, referring to a rectal examination with the finger. Doctors sometimes use it to refer embarrassment, disturbance, etc.]

One intern: 'Do you know what the professor of the eye department said in his farewell party when the students presented him a nice model of an eyeball?'

Others present said: 'Tell us.'

The intern: 'He said, "Thank god that I am not a professor of gynaecology".'

They all laughed.

In the junior doctors' room, informal teaching sessions also occur. When present, the senior doctors, particularly the medical officers and assistant professor, revise some orthopaedic lessons with the intern doctors.

The assistant professor, picking up an X-ray from a patients file said: 'Who can name this quickly?'

An intern doctor: 'This is a Monteggia fracture dislocation.'

The assistant professor: 'How many types of Monteggia?'

The intern doctor: 'Three types: anterior, posterior and lateral dislocation.'

The assistant professor: 'Which one is the most common?'

The intern doctor: 'The anterior one.'

The assistant professor: 'Perfect, very good, an extra somucha [snack] for you.'
Medical sales representatives are regular visitors to the doctors' rooms. When all the doctors are in the room, it is a good opportunity for the representatives of different pharmaceutical companies to market their products. The representatives offer the doctors their regular products, talk about some new products and give them related literature and sometimes also gifts. I witnessed one such encounter.

The medical representative: 'We brought a new IV saline in the market, here is a sample. Please keep this in mind when you prescribe saline.'

The casualty medical officer: 'Previously we used to write just saline but nowadays we also mention the name. So, we can write your product. Give me some literature about it.'

The representative: 'Yes, this is the literature about the product, I was about to give it to you. And here is a gift from my company for all of you.'

He gave a nice pen to all of the doctors present. Another casualty medical officer exclaimed: 'Hey, last week you gave everyone a calendar, I was not present. Where is mine?'

The representative said that he would keep it in mind and bring it next week.

'Who wants to make the incision?'

I have already discussed how operation day is an important day for the patients. It is an important day for the doctors as well, but for different reasons. The doctors look forward to the OT day because that is the day they have actual hands-on surgical training. The junior doctors particularly look forward to this day. Interactions in the operation theatre also demonstrate the hierarchical way of knowledge dissemination between the doctors.

Upon entering the OT, all staff slip off their own shoes and put on a pair of rubber sandals which they take from a row lined up beside the door. The doctors put on the white OT gown, cap and masks. Though the doctors do not wear white coats in the ward, in the OT they are dressed in white. Whenever I was in the OT, I also always had to wear a white gown. The patient was ready, lying on the OT table.

The CA said to the three intern doctors present in the OT: 'Sir [the professor] seems to be late today. I will start this patella operation today. However, I can give you the chance to give the incision. Who wants to give the incision?' One intern exclaimed: 'Boss, I want to give the incision. Another intern said: 'No, he has two more weeks to go; my duty is over this week. Please give me a chance, boss'.
The CA called the intern doctors over to settle the matter. When they were ready to begin, the CA could not find the X-ray of the patient; it was discovered that the X-ray remained in the ward. The CA scolded the ward boy who had brought him from the ward, and sent him again to fetch the X-ray.

There was a piece of paper stuck on the wall of the OT on which someone had written, 'Reminder: there is no sucker machine today in the OT. There is also no supply of cotton, Lysol or gauze.' The CA told me:

It's good that someone has already written it, otherwise sometime in the middle of the operation we would learn that there is no gauze supply from the hospital. Now we have already asked the patient to buy cotton, Lysol and gauze'.

I asked about the sucker machine. The CA replied:

That we will have to borrow from the general surgery, they have an extra one. We also have not had a drill for quite some days. I have a personal one, which I am using here.

The drill is one of the instruments most frequently used in the orthopaedic OT.

In the meantime, the ward boy had brought the X-ray, which the CA stuck on the window glass against the light and started to examine it with the intern doctors. Nurses were preparing the instruments. Everyone was waiting for the anaesthesiologist to come. Two of the anaesthesiologists were busy in the general surgery ward. The CA told me: 'They will finish there and then come to orthopaedic. General surgery always has the priority'. The assistant professor and the medical officers had also entered by then and began preparing for the operation they were going to perform in the adjacent OT room. The patient with the patella fracture was groaning and calling 'Allah' loudly. One medical officer said: 'This patient is making too much noise, it needs to be anaesthetized quickly'.

At this point, two ward boys brought a patient on a stretcher from the emergency room. Everyone became interested in the new case. It was a machine injury in which the patient's index finger was partially cut by a machine, but was still attached.

The CA examined the finger and asked the assistant professor: 'Will this finger survive?' The assistant professor said: 'Yes, one hundred percent.' One intern said: 'Sir, let me do it.' The assistant professor said: 'Well, tell me what you will do.' The intern: 'Have to give k-wire, isn't it.'
The assistant professor: ‘Yes, but remember that you need to attach the tendons properly otherwise they will not work. And oppose the skin loosely.’

The intern was very happy to get the opportunity to do the operation independently. It was a quick operation that did not need general anaesthesia. While the intern was doing it, the CA was giving directions and the other interns were observing carefully. After the stitching was complete, the hanging finger returned to its original position. Other doctors praised him. The fellow intern doctors were saying jokingly, ‘Bravo, Bravo!’

After some time, the anaesthesiologist came. ‘Is everything ready?’ he asked everyone. The CA said: ‘Boss, we were waiting for you for an hour. When you are in that room (pointing to the general surgery OT) you forget about us’. The anaesthesiologist laughed and started checking the machine and the gasses. The patella patient was anaesthetised. CA said to the interns: ‘You already had some training, now let me give the incision for this patient’. The CA started the operation by cutting the skin of the knee with the sharp surgical knife. Two interns assisted him. The assistant professor and the other medical officer went to the next OT.

After a while the professor entered into the OT where the CA was working. ‘How is it going?’ asked the professor. He stood beside the OT table and scolded the CA: ‘Your incision is incorrect. You were supposed to give a horseshoe incision, yours has become oblique’. Everyone remained silent. The CA continued the operation. The professor continued to watch. The patient was entirely covered with a white sheet, except for his knee, where the bones, muscles and blood were exposed under the bright OT light. After a while the professor said:

Don’t bend the patella, once it is bent it is spoiled. Leave the upper part and retract the lower. Your training is going to be finished within couple of months, and you still don’t know how to do a patella?

Everyone remained silent. The CA continued the operation. The professor continued:

Why are you pinching like that? You are not a cobbler, sewing a shoe. Each time you pinch, you are injuring soft tissue. When I was having my training I used to do the patella just with a nurse and you need ten assistants?

The CA did not reply. The interns remained silent. The professor again spoke, all the while watching the operation.
Push the wire properly, in foreign countries they have a wire twister, we don’t have one. So you will have to learn how to twist manually. Don’t push it like that. It’s not a matter of strength, it is a technique. You don’t need strong muscles for orthopaedic surgery; you need brains.

Everyone’s face was covered with a mask, so I could not observe their reactions. The CA was trying to stitch the wires around the patella, while listening to the professor. Suddenly the needle fell from his hand. The professor said: ‘You are hopeless, I hope you yourself will not fall down now’. The professor left the room and entered the next OT where the assistant professor was working.

The CA took another needle and completed the operation. Once the operation was over, the assisting intern doctors took off their gloves. One of them wrote the following operation notes: ‘Open reduction, internal fixation of the left patella by tension bend wiring’. As he took his gloves off, the CA asked me: ‘You see, is it possible to work properly if the professor continuously talks like this over my shoulder?’

No smiles for the patients

In the previous chapter on patients, I described doctors’ interactions with the patients from the patients’ point of view. I have shown how doctors objectify, ignore and humiliate the patients. Doctors rarely share any medical information with the patients. In this chapter I will present doctor’s own views of their behaviour with the patients and relatives.

One day, while in the doctors’ room, one of the medical officers drew everyone’s attention to an article in a magazine, in which a Bangladeshi person described his experiences of a hospital stay in Sweden. The writer discussed how badly behaved Bangladeshi doctors are in comparison to the Swedish doctors. I asked them what they thought about the article. An interesting discussion among the doctors ensued, one that reflected their views about the patients and their relatives in the present hospital. Along with the two casualty medical officers, the CA and two intern doctors were present in the room. The following are some of their comments.

Invite that Swedish doctor to replace me in this ward just for one shift. I want to see how sweetly he can behave. Today there are 123 patients admitted and we have only 92 beds. All the rest are lying on the floor, there is not even space on the floor to walk properly. All the senior doctors have left. Only the four of us here are present. The ward boys
and cleaners are in the lobby at a demonstration for their upcoming Class IV employee union election. Forget about medicine, there is not even any cotton supply today! How do you expect to behave nicely and keep your temper cool in such a situation? (Dr. Mahmudul Haque, casualty medical officer)

A few minutes back I was giving a treatment order to a newly admitted patient. You need to do some thinking to give the first treatment order. Suddenly a relative of a different patient came and started telling me: ‘Sir, please come and check whether the saline drip is ok.’ I was very irritated and scolded the relative badly. This is a stupid request. Moreover, I am not supposed to check the saline drip. He should have asked the nurse. Patients and relatives irritate the doctors with such behaviour. (Dr. Habib, intern doctor)

In which office in Bangladesh do you receive good behaviour? Nowhere. Then why should doctors be the only ones always smiling? I applied for a telephone at the T&T (the National Telephone and Telegraph office) but they want money to give me a phone. They won’t even look at you if you can’t give a bribe. Go to a police office with a complaint, they won’t put a case in the file unless you give them a bribe. You have seen in the paper other day that an engineer kept the overpass half done for months while negotiating a bribe with the contractor. The bridge fell down and people died. Now imagine, can I keep an operation half done in a government hospital and tell the client that unless you pay me money, I am not going to complete the operation? (Dr. Harunor Rashid, casualty medical officer)

Patients come here with false expectations. They have no idea what services are available in the hospital. When they see that nothing is available in the hospital they become irritated and then also irritate us. The government should have created an awareness program for the patients, to inform them about what to expect from the hospital. The government is the main culprit here, and it is invisible, while we doctors and patients are victims. The victims are confronting each other. (Dr. Shakil Ahmed, CA)

In the discussion with the doctors I raised the issue of the patients’ uncertainty about their condition and the doctors’ unwillingness to share information with the patients. Here are some reactions of the doctors about this issue:
That is another story. These are poor, illiterate people. How much you can tell them? What sort of negotiating can you do with them? Go and see bed number 67. The left leg of that patient has become completely gangrenous below the ankle. There is no alternative but to amputate it. But the patient and his relatives are refusing the operation. They keep asking me not to cut the leg. I am trying to make them understand that it is impossible to keep the leg but they don’t want to listen to anything. They are repeatedly saying that if it is necessary they will pay money, but that I should not cut the leg. What is the use of discussing the condition with such patients? (Dr. Shakil Ahmed, CA)

The complaints of the patients are never-ending. If you start listening to them, you will be trapped. Every patient thinks that his case is the most important one, and wants attention. But it is impossible to give equal attention to all the patients. (Dr. Andul Jabbar, intern)

I don’t think patients are that much interested about the diagnosis of their condition. Many patients just tell me ‘Sir, there is Allah in the heaven and you on the earth. Do what ever you think is best’. It is better not to provide them much information. The more information they receive, the more confused and worried they are. (Dr. Mahmudur Rahman, casualty medical officer)

During individual interview sessions, the assistant professor and the professor raised different points than what they had during group discussions.

There is no reason for the patients to be satisfied. We can never give them the ideal treatment. We cannot start the treatment on time. Also we discharge them early when they are just half-cured, because of the huge number of waiting patients. We cannot offer any rehabilitative facilities, which is an essential part of orthopaedic treatment. As a doctor this is very frustrating. We are also frustrated about our various professional problems. Sometimes patients become an outlet for releasing our frustration. Scolding patients probably neutralises our anger. (Dr. Bazlur Rahman, assistant professor)

This is not Europe or America where you can discuss the disease with patients. In the West patients are informed about various medical issues. But here most are illiterate people, what can you discuss with them? On the other hand, I must agree that not all the doctors are knowledgeable enough to give the patient a concrete answer about their condition, because only two of us in the unit are trained in
orthopaedic surgery. But I believe that even then some form of information should be given to the patients, which we actually fail to give. As for the behaviour towards the patients, I agree that doctors are rude with the patients. In fact there is no behavioural science training in our medical curriculum. It should be there. We should not be hot-tempered while we are working in the hospital in a developing country. We should be prepared for all sorts of constraints. It would have been ideal if we could have achieved that. (Dr. Hamid Ali, professor)

Inventiveness in medical practice

The doctors have various treatments that work within the resource constraints within which they are forced to work. They construct and invent their own ways of practising medicine, which does not always match the ideal ways prescribed by the textbooks. Personal preference also affects the manner of handling orthopaedic problems. For example, the professor of Unit Two preferred conservative treatment over operative treatment, which means trying to treat the patient with all possible non-operative ways before going for an operation, while the professor of Unit One prefers to go straight to operative measures. As a result, all the doctors of Unit Two follow their professor’s preferred way of treatment, and treat their patients conservatively. The casualty medical officer of Unit One said:

Some say that our professor is old fashioned and follows outdated British ways of dealing with orthopaedic problem, while the professor of Unit One, who follows American orthopaedic practice, is dynamic and speedy. This means that you do not wait, but open the body and go straight to the problem. This might sound smart, but we have to think whether we can afford that speed, whether we have those kinds of facilities. If we go for conservative treatment, it might take some time, but by avoiding the operation when possible, we save lots of poor patients’ money. So I support our professor’s way of practising.

Doctors also developed various local-made devices to solve orthopaedic problems, such as the use of bricks for weight for maintaining traction of the fractured lower limbs. The metallic weights advised in textbooks are not usually available and are very expensive, while the bricks are easily available. Though the exact weight cannot be maintained, they work.

One day I saw in the operation theatre one doctor using a shaving blade to do skin grafting. The doctor told me:
For small-scale skin grafting we often use this. Ideally you should use Hambi's knife for skin grafting, but where can I get that knife? Moreover it will cost about 300 taka (6 USD) while I can buy a shaving blade for 2 taka (0.04 USD). It works quite well. You only need to have practiced.

For the immobilisation of lower limbs the doctors usually use only a half-leg plaster, even when a full-leg plaster is indicated, because of the scarcity plaster materials. Likewise, whenever possible the doctors use local anaesthesia for correcting orthopaedic problem, though it is advised to use general anaesthesia by the academic books.

A girl with supracondylar fracture of the humerus (a fracture in the upper arm, around the elbow joint) was waiting in the operating room. The doctor showed me the book in which the treatment of supracondylar fracture with dislocation is written: 'Reduction should be done immediately under general anaesthesia by traction, counter traction followed by immobilization'.

He said:

If I want to follow the book I will have to wait another two hours, as the available two anaesthesiologists are engaged in other operations. So I will not wait for the GA [general anaesthesia] and will go for local. Even in some situations if the patient's condition permits we just do not use anything. All you need is to give a big jerk by hand so that the bone goes back to its original position. The patient might give a dramatic cry but by that time I have reached my goal.

The professor told me one day:

Yesterday I did a fixation operation. The book says I should use Down's brothers plate. Who is going to buy such an expensive plate? I did it with normal iron plate. There is a chance of infection but we will manage that with antibiotic coverage.

Doctors also find ways to minimize the drug and material shortage of the hospital. The CA once told me: 'We use the suction method'. 'What is that?' I asked. He replied:

You see, every now and then we find one or two patients in the ward who are relatively financially better off. We immediately seize the opportunity. When we write the list of the drugs and materials required for the patient and hand it over to the relative to buy those from outside, we always increase the number of the items. If the patient

147
needs twenty antibiotic tablets, we write thirty, if he needs two gloves we write four. Sometimes we tell the patient about it, but sometimes we do not. We 'suck' some of their money to buy extra medicines and materials, which we can use later for the poorer patients who cannot afford to buy them.

The doctors also sometimes exploit their relationship with the representatives from pharmaceutical companies to obtain materials for the hospital. When representatives from different pharmaceutical companies offer gifts to the doctors of the ward, and they frequently do, doctors sometimes request the representatives to donate something to the ward instead of giving them a gift. During my stay, one pharmaceutical company presented high quality covered files to keep the medical records of each patient as requested by the doctors.

The frustrated voices

When I talked to doctors one-to-one, they expressed their frustrations in various forms. Some have personal frustrations, some have frustrations about the medical profession in general and some have frustrations concerning orthopaedic surgery in particular.

I only see darkness in the future. What can I plan for the future, how can I plan? I am not sure what I am going to do once I am out of this hospital. All the government hospitals are saturated, government have very few job offers. This year the Bangladesh Public Service Commission offered about 70 government posts for the doctors, and I learned that about 2000 doctors applied. Ten years back, the government used to take a bond from the medical students stating that they would work for the government for at least for two years after graduating from medical college. But now the government makes students sign a completely opposite bond that states they cannot claim any job from the government after passing.

Private practice is the only way for us to survive. But the problem is, patients who have money do not want to come to a doctor who just has an MBBS and no post-graduate degrees. Patients run after degrees. Unless we have a proper post-graduate degree, we don't have a prosperous private practice. Again getting admitted to a post-graduate institute is another big war. So, I know quite well that life is going to be tough. (Dr. Riaz Ahmed, intern doctor)
This is the prime time of our practical learning. But from whom should we learn? All the senior doctors leave the ward after the morning shift. They have their private practices. The professor is involved in the doctors’ political association. They all have their various engagements. We are here with all our sincerity to work, but we don’t have enough knowledge and skill to deal with the patients. We don’t always find someone around to guide us. Only the CA is available all the time. But how many intern doctors can he guide? Moreover, he is also doing his own training. So in many situations we are just left alone in the ward. Sometimes it becomes quite embarrassing when we need to ask the nurse or a ward boy about some practical matters. (Dr. Ashfaque Hossain, intern doctor)

I remember one such occasion, in which a ward boy had to advise an intern doctor about how to give stitches. It was 3:00 AM in the night when a traffic accident case arrived. There was only one intern doctor on duty, and he was new in the ward. He was not confident enough to deal with the case. He did the surgical preparation of the wound and was preparing to make the first stitch. A ward boy was assisting him. The ward boy told the intern doctor: ‘Sir, I think it will be good if you start the stitches from below and gradually come upwards.’ Later on the ward boy added:

I have been working here for the last eighteen years and I still remember my first day in the hospital. I was very nervous. But everything became okay after a few days’.

It was interesting to observe the great embarrassment with which the intern doctor was taking lessons from the ward boy.

The casualty medical officer expressed his frustration regarding the extreme scarcity of medical supplies at the hospital:

Which problem of the ward should I name first? There are several. Everything is problematic here. Though it is referred as an orthopaedic ward, more than 90% are trauma cases. To handle trauma cases, you need instrumental support and investigation support. Which is almost nil in this hospital. We have to depend on the patients and outside laboratories for this. There is a very limited drug supply. You can see that we do not have enough beds. How can I give traction when a patient is lying on the floor? It is very frustrating to work as a casualty doctor in such a situation. (Dr. Mahmudul Haque, casualty medical officer)
The register pointed out the problems of teaching orthopaedic surgery:

The students don’t pay much attention to orthopaedics. The orthopaedic ward is considered to be a peripheral ward. General surgeons have taken the central position. The syllabus has been made in such a way that students do not pay much attention to orthopaedic surgery. Rotation duty of intern doctors is also not sufficient. They spend six months in general surgery but only a few weeks in orthopaedics. But there are lots of technicalities involved in orthopaedic surgery, which require practice. Orthopaedic surgery should get high priority in the context of Bangladesh. There is no road safety, hundreds of people are dying everyday from road traffic accidents. The criminal amputation and assault has increased many times. We need a separate trauma hospital. But general surgeons are dominating the field; we orthopaedic surgeons are lagging behind.

Some doctors, however, say that they do not find orthopaedic surgery academically interesting. They say it is more of a manual kind of work, and not intellectually challenging like internal medicine. But that’s not true. Orthopaedics is also intellectually challenging and exciting. Take the tendoachilles operation. It’s an adventure to unite all those separate tendons and ligaments. Students are not given enough time to experience those excitement. (Dr. Farid Ahmed, register)

The clinical assistant, the busiest doctor in the ward, talked about his personal disappointments.

Maybe my forefathers were Dracula, that’s why I love blood and chose surgery. [He laughed.] Actually I like the dynamism of orthopaedic surgery. You identify the problem, go straight to the problem site and solve it. It is not like catching a black cat in a dark room, like with the internal medicine department.

I am trying hard to learn it. But you have seen how tough the professor is. He is always scolding me. I am always scared in front of him. But most of the professors are like that you know. They are powerful and they want to show their power. My colleagues tell me that the scoldings of professors are blessings. It helps in the end. But I would be happy if he would give me some more advice and demonstrations along with the scoldings.

However, my religious belief gives me confidence. I try to be faithful to my duty. I never can be deceitful with my duty. Because I know it is not the professor but Allah who is watching me.
I am not sure about my future. After this training I will be qualified to sit for the post-graduate exam. That is another war, you know. So much competition there. If I have the blessings of Allah, I will qualify. So the future is still uncertain. (Dr. Shakil Ahmed, clinical assistant)

The assistant professor justified the private practice of the doctors during hospital hour:

Why should the doctors not have their private practice? How much does the government pay a doctor? It's nothing. I cannot even pay my house rent with my salary. All my non-doctor friends are richer than me. I recently met one of my schoolmates in Dhaka who has a big house and two cars. But he was one of the worse students in our class! I was always in the top of the merit list and he used to come to me for his homework. When I was reading, he used to sit in a restaurant and drink tea, smoke and gossip. Then I entered the medical college and after five years of rigorous study I became a doctor. Meanwhile, my spoiled classmate took just a graduate degree from a local college and started business. It must be a sort of smuggling business. Now he is a millionaire. I was almost feeling shy when I entered his palatial house. I don't have a car and I am living in a rented house. All those engineers, police officers and lawyers are becoming millionaires by exploiting their professional position. Why do people expect that only the doctors will be loyal to government and live a life of a saint? (Dr. Bazlur Rahman, assistant professor).

The professor talked about the professional politics among the doctors, the loss of dignity of the medical profession and about his personal failures:

I was inspired by Professor Gust and got interested in orthopaedic. This German professor established the first orthopaedic and rehabilitation hospital in Bangladesh after our war of independence. We had several disabled liberation fighters, so it was crucial to have a rehabilitation centre for them. Dr. Gust organized that. I was a young doctor at that time, inspired by our liberation war and independence; I thought that this was an area of specialization through which I can serve the nation. Dr. Gust's commitment in this regard inspired us. But unfortunately we could not keep up with that commitment. Last year Dr. Gust came to visit Bangladesh after many years. He was very disappointed with the poor condition of the only orthopaedic hospital
in Dhaka, which he established. He was so shocked to see the dirt around the hospital that he started to sweep it up himself.

The whole country has become corrupt. Politics are corrupt. Everyone just wants to make money, wants to become rich. The doctors want to become rich as soon as they finish their internship. The senior doctors are also just running after money. Taking commission from all investigating centres, by referring patients to them. They are busy in clinic business. Who has the time to think about the development of medical profession or bring some improvement in their own discipline? There is no appreciation for research. I have a number of publications, I wrote books, but those do not have any value. I am still an associate professor and most of my contemporaries are already professors. They did not promote me. You need good connections with the public service commission people. It is also possible to get a promotion by giving them a bribe. Some very low calibre doctors are getting quick promotions because of their connections with the ruling political party. The medical association is doing business with transfer and posting of the doctors. I joined the association to fight against all these immoral practices of doctors and regain dignity but it is hard.

(Dr. Hamid Ali, the Associate Professor/Unit head)

Summary and discussion

A mixture of contempt, frustration and inventiveness constitutes the professional selves of the doctors of the ward. A sense of hierarchy and an intellectual arrogance are generally considered to be the main characteristics of the biomedical physician, and this sense has been internalised through the training of the doctors (Floyd & Davison 1987, Groopman 1987, Palgi & Dorban 1997).

In a Bangladeshi hospital, the practice of these characteristic traits has a more robust quality. Doctors of the orthopaedic ward are at the top of the hospital staff hierarchy, and doctors display their superiority in various forms in everyday life of the ward. The space and resource allocation in the ward for the doctors [separate rooms, toilets, chairs] also clearly demonstrate their superiority. The daily grand round of the doctors is one of the vehicles for the articulation of professional boundaries and the enactment of status for physicians as a group. Weiss (1993) discussed the ritualistic value of grand rounds to restate and formalise the status system of the doctors. During the round, the doctors demonstrate their authority over the general public, other staff as well as over the patients. We have seen how doctors dominate the scene, while others remain as silent, minor actors during the round. Intimidating patients and their relatives through the widespread practice of
scolding by the doctors and in the form of jokes and humour about them is another way of affirming hierarchy. Again, although a certain degree of objectification and depersonalisation of patient in a teaching hospital is inevitable (Atkinson 1995; Mizhari 1985), the rejection of expressing empathy to a distressed patient by the Bangladeshi doctors is remarkable (Wilce 1997). Doctors are proud of their profession and keen to maintain their prestige. They organised a strike in order to protect the prestige of this honourable profession, despite the great suffering it caused the patients.

Historically, medicine has been regarded as a high status profession in Bangladesh. For many years, medical education was not open to native Indians in colonial India. At the turn of the twentieth century, only very few Indians had managed to graduate with a degree in Western medicine (Harrison 1994:15). As a result, those who became doctors in Western medicine were considered especially fortunate and privileged; medical graduation became a passage into affluence. This image of a doctor as a successful member of high society remained alive in the post-colonial Indian subcontinent. It is interesting to observe that many romantic heroes of 1950’s and 1960’s Bengali movies and novels were doctors. A very popular 1950’s Bengali movie, entitled ‘Hospital’, depicts the highly affluent life of the main character, a doctor, who converses with his father in English, has a palatial house, a big car and a big pet dog.

In present-day Bangladesh, getting admission in medical colleges is highly competitive. A nationwide entry exam for medical colleges with written and oral tests is held every year. Only students with high academic qualification get admission. This initial success also gives medical students a sense of pride that they carry with them even when they are doctors.

I have described how the doctors maintain their group solidarity through the ritual of nasta (tea break). During the tea break the doctors socialise among themselves and exchange ideas of common interest. They learn from each other various medical and professional tricks and make jokes using slang expressions or parodies of biomedical terminology. Authors have argued that verities of verbal humour among doctors working in the hospital works as a coping mechanism for dealing with anxieties created by death, uncertainty and the stress of professional practice (Coser 1962; Fox 1974; Tolpin 1989; Weiss 1993). Thus, nasta remains a means to maintain doctors’ group bond and sanity.

However, although doctors are unified from the outside, they are divided within. There is a clear hierarchy and difference in status between the doctors. The most senior doctor, the professor, remains firmly at the top. I have described how the he exerts his control over the ward personnel in a personalised way. Jahangir (1982) gives an historical and cultural analysis of this particular phenomenon of personalisation of authority in Bangladesh. He
showed that historically, Bangladeshi people did not know or care much about the regime, but were more interested in the Zamindars/Mahajon (land lords) he had contact with. He appraised these largely according to how they used their authority to give patronage. The Zamindar is obliged to be authoritarian to control the subordinate and to protect himself. Similarly, an officer in an organisation in Bangladesh today is expected, like the Zamindars of the past, to be authoritarian. It can be seen in organisations in Bangladesh that the officers customarily speak sharply to their subordinates, and they commonly reinforce their position by generating fear. This authoritarianism is also encouraged from early childhood in Bangladesh. For example, the father and elder brother/s are symbols of authority to be feared and obeyed. The father hardly plays with the child after age 3 or 4, as this might dilute his authority. The bureaucratic and training institutes of Bangladesh are similarly shaped according to the same wider social hierarchy (Ahmed 1980; Huque 1990; Selim 1995). The commanding professor therefore actually played his socially expected role. It is also interesting to observe how personalisation of authority affects the local construction of medical knowledge. I have described how the doctors of the Unit Two orthopaedic ward prefer the ‘British’ way of dealing with orthopaedic problems, rather than the ‘American’ way, because that is what the professor prefers.

However, in spite of their authority and pride Bangladeshi doctors have many frustrations. The roots of these frustrations are embedded in the general socio-economic malaise in the country. Firstly, they are deeply frustrated with their work environment. Generally, however, medicine is widely considered to be a stressful profession. Authors discussed the latent tension within medical work and psychological vulnerability of doctors (Palgi & Dorban 1997, Weger 1992). A new diagnosis was even added to the medical nomenclature called ‘The Impaired Physician Syndrome’. It is an illness suffered by the doctors and caused by their working environment. Fox (1980) writes about the tragicomic hospital world, where uncertainty and death are the only certainties. Bangladeshi doctors are extra stressed as the medical uncertainties are multiplied by numerous practical uncertainties. They have to work within extreme scarcity of resources and with insufficient manpower. This highly limits their capability and prevents them from getting job satisfaction.

However, I have also described how the doctors developed various indigenous way to deal with these practical constrains. They ignored the textbook in many cases and developed their own way of dealing with orthopaedic problems, like using razor blades for skin grafting, using building bricks as weights and avoiding general anaesthesia. They exploited financially solvent patients and pharmaceuticals to obtain extra medicines and equipment for the poorer patients. Streefland (1995) discussed how a practice could be
sustained through contextual permeation and active adjustment of the formal rules to the local environment in connection to immunization program.

Secondly, they are frustrated with their low governmental salary, with which they are unable to maintain their living standard. As a result, almost all the doctors are engaged in private practice. To maintain their private practice, the doctors have to leave the hospital before their office hours are over. Gruen et al. who studied the practice of holding dual jobs by Bangladeshi doctors wrote:

Doctors have adopted individual strategies to accommodate the advantages of both government employment and private practice in their career development, thus maximizing benefit from the incentive provided to them, e.g. status of a government job, and minimizing opportunity costs of economic losses e.g. lower salaries (Gruen et al. 2002:267).

Extra income generating activities by doctors as coping strategies to maintain an acceptable standard of living are observed in many other developing countries (Alubo 1990, Ferrinho et al. 1998, Roenen et al. 1997). Alubo, for example, discussed how in Nigeria, in contrast to the general stereotype that medicine is a philanthropic science in the service of humanity, it has been commodified and has become a lucrative business. He writes: ‘...doctors and other medical entrepreneurs are responding to the objective reality of an acquisitive material society and the overall capitalistic system’ (Alubo 1990: 319).

Thirdly, Bangladeshi doctors are frustrated because they feel that the social image of doctors has come under pressure in recent years. They feel that the general image of the medical profession as a whole has become tarnished, and that people are displaying less respect towards them. Bangladeshi doctors are not afraid of lawsuits by the patients like their American counterparts are (Annandale 1989), but there are concerns about the regular journalistic accounts that describe the malpractice and the business-mindedness of Bangladeshi doctors. Instead of lawsuits, many patients, particularly the rich, bypass the Bangladeshi doctors altogether and seeks treatment in neighbouring countries like India, Thailand and Singapore (Paul 1999, PHAB 1999). Reasons the patients mentioned for bypassing Bangladeshi health care included (but are not limited to) the lack of confidence in the competence of the Bangladeshi physicians, their rude behaviour towards the patients and their money-mindedness. The doctors think that the threat to their social image is mainly due to false and ignorant journalism and partly due to the fault of some greedy doctors.
In summary, the majority of the doctors in present Bangladesh do not generally enjoy the satisfaction, prestige and affluence of their counterpart in colonial and early post-colonial period. They are not the heroes they used to be.