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

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Chapter X

THE HOSPITAL: MIRROR OF SOCIETY

In previous chapters I have described how the social dynamics of the work of doctors, nurses, ward boys, cleaners, gatekeepers and of the lives of patients and their relatives in the ward combine to form a distinctive hospital culture. In this chapter I will discuss how this hospital culture mirrors various features of broader Bangladeshi culture and society. Although no microcosm can perfectly mirror the whole, an in-depth exploration of one place can reveal the basic dimensions of the larger picture. As Margaret Lock wrote: ‘The study of health, illness and medicine provides us with one of the most revealing mirrors for understanding the relationship between individuals, society and culture’ (1988:8).

Generalised poverty

As I am writing this book, somewhere in the world a seminar is being held on poverty alleviation strategy for Bangladesh. Jensen wrote, ‘Today there is hardly any country in the world where so much poverty is concentrated in so small an area’ (1999: preface). As a result, a fundamental aspect of the Bangladeshi mindset is ‘...the constant awareness and nearness of cataclysmic plunges into poverty. No one can escape the fear of poverty or live beyond its chilly grasp, even those at the highest levels’ (Novak 1994:101).

If we recall the ward of Chittagong Medical College hospital, one of the major government hospitals of Bangladesh, we readily recognise how it reflects the general poverty of the country. One can see, feel and smell poverty in every aspect of hospital life. We have seen how the hospital receives only half of its required budget. This limited budget, in turn, generates an environment of chronic scarcity of materials like cotton, gauze and scissors as well as of manpower in the hospital. Poor patients need to buy nearly all required drugs and even some instruments for their treatment. These expenditures financially ruin the patients. We have seen too how the patients’ relatives take over all the nursing responsibilities, as there are not enough nurses in the ward to complete all of the paperwork and take care of the patients. Patients wait for hours in the operation theatre as the only anaesthesiologist is engaged in other wards. The salary that the staff is paid is inadequate for maintaining an acceptable standard of living, which forces them to find other income generating activities, so the doctors leave the hospital early to start their private practice. The low-paid lower level staff exploit their indispensable position by demanding tips from the patients and by other
ingenious and not necessarily honest means. Poverty thus broadly dictates the reality of the ward.

Poverty is a recurrent theme in any discussion concerning Bangladesh. According to the broader definition of poverty:

Poverty refers to forms of economic, social, and psychological deprivation occurring among people lacking sufficient ownership, control or access to resources to maintain or provide individual or collective minimum levels of living (Hye 1996:4).

There are, however, differential use of the word ‘poor’ or ‘garib’ in Bangladesh. The main ruling and the opposition political parties frequently use the word ‘garib’ in their election manifesto and claim themselves pro-poor. They promise to create a national budget that will improve the life of the poor. However, Marxist political parties, relatively smaller in size, dismiss these promises as propaganda and explain poverty in terms of class exploitation and global capitalist imperialism. They demand total transformation of the social structure in favour of the exploited poor. There is also the journalistic use of ‘garib’, in which Bangladesh is compared with other Asian countries like Taiwan, South Korea or Malaysia and described as poor in various economic terms. The word ‘garib’ is also in common use among development agencies, as they try to achieve measurement and precision in selecting target groups for their various programs. These agencies measure poverty in terms of calories consumed per day or in a combination of land holdings and income per day. According to these definitions some seventy percent of the people are poor and some thirty percent live in absolute poverty. Maloney (1986) mentioned yet another use of the word ‘garib’ in everyday conversation of Bangladeshis. He observed that one often informed a person of relatively higher status that he is poor; even a middle class farmer or a salaried person may do this, though he may not be poor by Bangladeshi standards. While the Westerners are accustomed to hiding or denying poverty, many Bangladeshis keep on repeating that they are ‘garib’. He rightly argued that what a Bangladeshi means by using the word is to set up a relationship of inequality between himself and the person addressed in anticipation of possible patronage, or at least in a statement of the moral social order in which he needs to make his relationship function.

There is a range of explanations for the poverty of Bangladesh. When the subject of persistent poverty is raised with my Bangladeshi acquaintances, the initial response is often to blame outside forces. Though looking outside for causes of problems is a normal defensive response and is often much easier than looking inwards, there are indeed very powerful external causes of poverty in Bangladesh. Among the external causes, there are natural disasters
like floods, droughts, cyclones and lack of natural resources. Additionally, there are historical causes.

Many scholars have also discussed the causes of poverty in Bangladesh. According to Hye, the answer to the question why an individual is poor should be the same as the answer development economist Ragnar Nurkse gave to the question why a poor country was poor: ‘A person is poor because he is poor’ (1996:17). Nurkse knew the answer was tautological and too simplistic, but what he wanted to get at was why a country is poor in the first place. Poverty was a kind of puzzle that he wanted to be solved through the use of a vicious circle as the analytical framework.

At a general analytical level applicable to most of the Third World countries, it has been argued that poverty arose from the way these countries were incorporated into an international economic and political system dominated by the industrially developed capitalist countries that were also colonial powers. In the chapter concerning the history of Bangladesh, I mentioned how it was exploited by various colonising powers. Bangladesh was not mired in poverty prior to colonisation. Once Bangladesh was an enviable area, whose wealth supported the Moghul Empire and later provided the surplus that allowed the British to finance their expansion in India:

Unlike the time when Muslim power declined and Bengal had been reduced to beggary and had become a byword for poverty and backwardness. It is difficult to imagine how it feels to fall so low. How low Bangladesh has sunk from the days when Jean Law, one of its first European visitors, reported that ‘in all of the official papers, firmanas and parwanas of the Moghul Empire, when there is a question of Bengal, it never ends without adding these words, “the paradise of Nations!”’ (Novak 1993:82).

West Pakistanis continued to exploit Bangladesh economically during the Pakistan period after the British left India. Today, industrialised countries still continue to exploit Bangladesh in the form of various unequal business terms.

Thus, the current-day poverty of Bangladesh is a result of a mixture of external and internal factors. In spite of some progress since independence, the high rates of population density, population growth, illiteracy, morbidity and mortality, as well as low industrialisation and inequitable distribution of income and social opportunities continually challenge the poverty alleviation of Bangladesh (BIDS 2000).

A government hospital of Bangladesh therefore obviously suffers from this overall grasp of poverty in the country. The government hospitals also particularly suffer because of the low budget allocation for the health sector of the country. It is worthwhile to mention that there are influences of various
political interests in distributing the limited national budget to different ministries. Maniruzzaman (1994) discussed how due to the legacy of direct and indirect army influence in Bangladesh politics, a large amount of budget goes to the country’s defence forces. The health ministry is weak and unable to secure enough money from the national budget so the health sector particularly suffers because of this inequitable budget distribution. The Bangladeshi per capita government expenditure on health is less than 3 USD (BBS 2000). Begum wrote: ‘in both capital and revenue budgets the government has to allocate the lion’s share to the defence sector in order to appease the armed personnel’ (2001:52). She mentioned that the distribution of the total revenue of the Bangladeshi government, 3,617,800,000 taka for the fiscal year 1999-2000, shows this tendency. For the health sector, only about 252,000,000 taka have been allocated, while the allocation for the defence sector is about 299,700,000 taka. Moreover, less than one-fifth of the national health sector expenditures in Bangladesh are for hospital services (Perry 2000:29). In addition to this inequitable budget distribution at the national level, there are also local-level politics within the hospital. The internal distribution of the limited budget allotted to the hospital is not done according to the need of the departments, but rather depends on the ability of the department to influence the administration. The doctors of the orthopaedic ward complained how the general surgery department dominates the orthopaedic department and receives the bulk of the budget.

It is therefore interesting to observe that while the Bangladeshi government is buying a new fighter jet for its air force and the operation theatre of the general surgery has the necessary instruments ready, the professor of the orthopaedic ward is shouting at everyone because the only pair of scissors in the ward is missing.

Social hierarchy

Social hierarchy is a characteristic feature of Bangladesh, just as it is in many other South Asian countries. A number of observers of Bangladeshi culture noted the remarkable preoccupation of Bangladeshis with social status and rank:

Every individual [in Bangladesh] knows and is quick to estimate who is above and who is below him. Indication of rank is displayed in casual conversations and official inquiries, whereby persons are specified by references to skin colour, size of salary, academic degree and birth order within the family (Kotalova 1996:148).
Van Schendel also discussed the value of status display in Bangladeshi society. He captured the poignancy of it in the description of the impression management ritual that he observed two villagers, relative strangers, who met on a village path, engaging in.

Their greeting usually led to a rapid verbal status display on both sides. Unless one of the two quickly concluded that he was inferior in status and signalled it by acting deferentially, this could lead to a true ‘barking contest’, an escalation of status claims and counter claims (Van Schendel 1981:242).

Life within the hospital ward that I have described clearly demonstrates this social value of hierarchy. The interactions within the ward show a robust concern on the part of the staff to define the boundaries and maintain the institutionalised inequalities between the doctors and the patients and their attendants and between the different grades of staff. The professor, with the highest academic degree and the senior-most position, remains at the top of the hierarchy and demonstrates his power through giving orders, scolding and intimidating every other member of the ward who is below his status. Similarly, the other actors also behave according to their status and position. Junior doctors exercise power over nurses, ward boys, cleaners and patients. Likewise, nurses do the same with ward boys, cleaners and patients. The language, gestures, and overall demeanour of the staff members indicate who is ‘big’ and who is ‘little’ in the ward. The confused patients recognise the relative rank of the staff members by observing who talks and who remains silent and who shouts at whom.

The space allocation and facilities in the ward also show the status difference. The professor has a well-furnished, carpeted, private room with an attached bath, while the junior doctors have a smaller common room with poor quality furniture. The nurses have a much less private common room in which the chairs are broken. The ward boys and cleaners, on the other hand, do not even have the luxury of their own rooms in which to sit.

Chairs also indicate hierarchy, as do tea breaks. The chairs in the professor’s room are placed in a hierarchical manner. The chairs with armrests, closer to the professor’s table, are meant for senior doctors, and chairs in the back row without armrests are for junior staff. Moreover, not everyone is allowed to sit in the presence of the professor. A junior nurse or a student would not usually sit while in professor’s office. The gatekeeper is not entitled to sit on a chair, rather he is given a stool. The doctors sit in these chairs each and every day as they socialise among themselves over tea and snack. Staff from the lower grades do not enjoy this everyday ritual. Lower level staff have their tea outside the ward, in their cafeteria.
The status of patients and their relatives is even below that of the lowest level hospital staff, even if the patients are of middle class standing. They are scolded and humiliated by all levels of staff members. Even the lowest level staff, the ward boys and cleaners, humiliate the patients and exploit them economically. Despite their lower social and economic status, ward boys and cleaners are able to attain a status higher than the patients through their ‘social capital’ (Bourdieu 1977), i.e. their experience, connections and skills related to the hospital. Thus the poor and physically and mentally crushed patients remain the most vulnerable within the hospital hierarchy. The patients have almost no voice in the ward. They are continuously objectified, their questions are ignored and their privacy is limited. The space allotted for each patient is minimum; in fact, it is so small that the accompanying relative needs to sleep under the patient’s bed during the night. The toilet for the patients is the dirtiest, and most of the time there is no running water. There is no organization in Bangladesh that upholds the ethical issues of medical practice and protects the legal rights of patients (Begum 2001). It seems as if the patients, who are the very reason of all the activities of the hospital, are virtually nobody.

From the Marxist perspective, hierarchical behaviour is a feature of a class-divided society. Hierarchical behaviour is more likely in countries like Bangladesh, where there is extreme inequality of power, influence and opportunity. However, various traditional values also generate hierarchical behaviour in Bangladesh. A number of authors have discussed how the wider social customs of hierarchy have shaped the bureaucratic and training institutions of Bangladesh (Ahmed 1980, Huque 1990, Jamil 2002, Selim 1995). Jamil (2002) argued that the administrative culture in Bangladesh is characterized somewhat more by traditional than by modern governance norms. He showed how the wider societal values of samaj influence the public bureaucracy of Bangladesh. Etymologically, samaj is rooted in the notion of ‘going together’, although in its modern usage, it is rightly translated as ‘society in general’ or in more limited context, ‘association’ (Chowdhury 1995). The samaj pattern is taken as the basic frame of reference for social activities. The samaj has the authority to award punishment if anyone deviates from the established social norms. Every individual is conscious of the controlling authority of samaj (Aziz 1979:26).

Maloney (1986) argued that the principal of hierarchy in interpersonal relations in Bangladesh is inbred since childhood, when people first experience themselves in subordinate-superior relationships. He discussed hierarchy in relation to patronage and indulgence. He argued that the concept of daya, which means ‘grace’ or ‘being blessed’, is fundamental in Bengali culture. The expectation of daya begins in infancy when the child receives nurture and indulgence over a prolonged period of time. The median length of
breastfeeding is between 19 and 24 months, usually until the next baby arrives. The baby (sisu) stage lasts 5 or even 6 years. Maloney discussed Sudhir Kakar who had written in detail on the psychological effect of the long nurture period and the resulting mother-child bond in South Asia. The school-age child learns that the father, father’s elder brother, and his own elder brother 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 father can demand physical labour and service on one hand, but can give *daya* and blessings on the other. The mother and mother’s brother are typed as indulgent. Children learn to beg for indulgence and favours, and in this pattern of social relations such begging is, to some extent, even a form of showing respect to the elders who are thereby accorded the status of giver of the indulgence. The power of a very old person resides largely in his capacity to grant this abstract indulgence. The beggar, too, feels he is entitled to a little redistribution of goods, which he should receive as a blessing from the donor. It is the donor’s duty and also his own blessing to give, for which the presence of the beggar provides a chance of fulfilment. The donor’s relative status is acknowledged and no thanks are said. If one cannot give to a beggar one says, ‘*maf karo*’, ‘forgive me’. Maloney thus wrote:

This pattern is extended from the family to the work place and to society in general. In daily intercourse a person with higher rank is accorded the right to extract labour, service, and respect from persons of lower rank (Maloney 1986:43).

We have observed that the extraction of labour, service and respect from persons of lower rank by the persons with higher rank is a very common practice in the orthopaedic ward. Although the *daya* or indulgence aspect of this analysis is not blatantly evident in the hospital context, we can see traces of the idea, if we recall that the Clinical Assistant was told to consider the non-stop *boka* (scolding) of the professor as blessings.

The hierarchical behaviour in Bangladesh is also embedded in the sense of *izzat*, or honour. *Izzat* in Bengali culture is a moral substance, a standard of distinction that has to be gained and defended (Kotalova 1996:124). Among many things that *izzat* is associated with in Bangladesh is distance from manual work and dirt. The poor people, who are generally uneducated, usually do the manual work, the dirty conditions in which they live and work eventually affects their *izzat*. To maintain their *izzat*, the rich and educated keep themselves away from manual work and dirt. Thus, any work in the hospital involving dirt is done by the lowest hospital staff. The doctors delegate any petty manual tasks, like fetching a file or a cup of tea, to the ward boys or the cleaners. Likewise, the nurses try to avoid close physical proximity of the poor patients and busy themselves with relatively prestigious tasks like writing
reports or giving injections. As one of the nurses said, 'too much identification with the public diffuses our izzat.' She wished she were a school teacher rather than a nurse, which would allow her to avoid such regular contact with public. Maloney observed that in Bangladesh the concept of education is not just the acquisition of knowledge, rather its function is also to distance the 'educated' from the farmers, artisans and labourers (1986:32). In other words, the function is to distance the 'educated' from manual work. The case histories of manual labourer patients that indicated their poor occupational safety has also to do with this social hierarchy. We may also recall the concern of the patient who was a school teacher, regarding his loss of honour due to his placement on the dirty floor along with other poor labourers.

This notion regarding the relation between dirt and social prestige is again related to a deep religious sense concerning purity and pollution. Blanchet (1984) discussed how ritual purity and its opposite, pollution, are dominant themes in both Hinduism and Islam, the two main religions of Bangladesh. In both, ritual purification is a prerequisite to religious activities. Elaborate rules on how the body should be cleansed of all its impurities before approaching God are laid down in the book of Manu and the Quran. In Hinduism, pollution is a state that is inherited and serves to hierarchically rank various occupational groups. There is list of impure occupations, which are generally all manual labour jobs. On the other hand, among the Muslims, the notion of purity and pollution is not expressed in an elaborate caste system but it marks nonetheless the relationship of men with spiritual powers as well as the relationship of men among themselves. In Islam, purity is linked with auspiciousness. Good health, success and prosperity are expected to be found chiefly among those who are closest to God, so to speak, the upper class bhadrolok, whose lifestyle is said to be cleaner and whose state is purer, both physically and ritually. People living in poverty, on the other hand, are more often affected by dirty conditions, which confirm the inauspiciousness of their lives and the distance that separates them from God. Although this theory that links auspiciousness and purity does not fit with the contemporary society as strongly as did in the past, it still accords with a hierarchical structure of the Bangladeshi society. In the hospital, dirt is always associated with lower level staff and poor patients.

Because of economic class divisions, religious beliefs in purity and prestige as well as the cultural notion of indulgence, the practice of social hierarchy remains a distinctive feature of Bangladeshi society. As in the orthopaedic ward, where there is a concentration of people of different social statuses, it becomes a platform where the practice of social hierarchy takes on an intense form. The patients who are mostly economically poor, uneducated manual labourers, and who, as a result, are ritually impure and have no izzat, are considered to be nothing. They do not even rest at the bottom of the
hierarchy; rather they are out of the hierarchy. In a matter of speaking, the hierarchy of the hospital is bottomless; it knows no lower limits.

The value of family

We have observed that family members play a crucial role in the life of the patients of the orthopaedic ward. One family member usually accompanies the patient in the ward throughout the period of hospitalisation and provides all kinds of nursing care to the patient. S/he helps the patient with feeding, washing and using the toilet. S/he also helps with the medications and dressings of the patients. Family members play an intermediary role between the patient and the ward staff and the world outside the hospital. They take part in various decisions concerning the treatment of the patient and also provide regular economic and emotional support to the patients.

The life of the patients in the ward shows the crucial role that families play in an individual’s life in Bangladeshi context, including in his or her therapy management. A Bangladeshi patient is never an individual actor or decision maker, the family provides all sorts of economic, social, emotional and psychological support to him. Medical care involves expenditure of time and energy by the patient’s relatives, and money for the treatment also comes from family funds. Unlike in many Western societies, Bangladeshi families do not consider it to be a morally correct act to delegate the duties of caring for their sick kin member to professional caretakers. There is a relational obligation for a family member to be present beside a sick member throughout his or her illness. This is embedded in the fact that Bangladesh is a society in which people are organized mainly through primary relations, which prevent them from being segregated from the activities of everyday life.

Inden and Nicholas showed how family bonding is a prominent feature of Bengali culture, both among Hindus and Muslims. They wrote:

When Bengalis are asked whom they invited to a daughter’s marriage, they commonly reply ‘our atmiya-svajana’ (...) The term atmiya comes from the reflexive word atma and means ‘one’s own’ [I would add that it can also mean ‘soul’]; the term svajana means ‘one’s (sva-) people (-jana)’. Both terms combined together are used in Bengali to designate ‘one’s own people’ (Inden & Nicholas 1977:3).

These ‘own people’ are considered as the source of love:

Love is conceived of as an attraction, the ‘pulling together’, or ‘binding’ of kinsmen, which causes them to desire one another’s well-being (mangla, kanlyana), and to obtain it be selflessly ‘caring for’
(palana), ‘nourishing’ (posana), and ‘supporting’ (bharana) one another. Following this code for conduct, kinsmen are thought to retain their solidarity with one another and thereby to obtain pleasure, delight and gratification (ananda, tripti and santosa) (Inden & Nicholas 1977:21).

Gusthi is the basic kin segment of Bengali society. A group of households or families comprise a gusthi. In such a case, all these households or families are agnatically related with the exception of in-marrying wives and out-marrying daughters (although after marriage, a woman may acquire the gusthi membership of her husband). A gusthi, therefore, consists of all the male patrilineal descendants of a great-grandfather. Common ancestry provides a sense of belonging that binds together the members of a gusthi. A gusthi is, therefore, a patrilineage. Members of the lineage can trace their common origin to a single deceased male ancestor. In a gusthi all members have a common ancestor, traceable by a genealogical tree (Chowdhury 1995). The possible gusthi network is very large and complicated in Bengali culture, for there are some 215 kin terms in Bangla (Aziz 1979). The gusthi may last a long time, or become a faction or expand, or shrink, or split, mostly according to the strength and behaviour of the leaders within it. The bigger the network, the stronger the gusthi, the safer the individual members. This is particularly crucial in the context of Bangladesh, where there is no alternative institutional support system for its citizens. Kin are therefore the main source of support in any crisis situations. As a result, there is a continuous desire and effort on the part of the individual to expand and raise the standard of the kin, thus increase the survival strength. Instead of investing in banks or insurance, people ‘invest in people’ (Van der Veen: n.d). Kotalova wrote how marriage in Bangladesh is a core rank-generating transaction rather than a personal adventure (1996:162). Novak mentioned the ‘clannishness’ of Bangladeshi society, where nearly everyone can identify up to seven or eight generations of his or her forbearers, where friends or acquaintances, even foreign ones, are called ‘cousin’, ‘brother’ or ‘uncle’ depending on relative age. He observed that:

Once one moves into the larger society, relatives are always available to smooth the way: to provide introductions for jobs, to help arrange school entry, to stop or divert some official action, to provide a “home” when one is in need. On a larger scale a huge patronage web exists that affects all clan members (Novak 1994:106).

There is even a practice of fictive kinship called dharma atmya among both Hindu and Muslim Bengalis (Sarker 1980). This relationship is based on mutual choice of candidature and is later sanctioned by responsible family
members. Every dharma atmya relationship involves mutual aid in times of need and distress, which brings mutual security to enhance community solidarity. I have mentioned how temporary fictive kin relationships of uncles, aunties, brothers and sisters arose among the patients and relatives in the orthopaedic ward which became the basis of providing mutual help to each other.

The pattern of family structure has, however, changed in Bangladesh over the last few decades. Nuclear families have largely replaced the traditional joint family structure in Bangladesh. For some authors, urbanisation and modernisation are the force behind family change in Asia (Knodel & Debaulya 1992), while for others, poverty that weakens the family ties is the reason behind change in family (Adnan 1993). Some discussed the change in relation to the decline in fertility in Bangladesh (Cleland 1993). Despite these changes in the family structure, the family still remains the strongest institution in Bengali culture and main source of support for individual, perhaps due to the absence of alternative social networks. While discussing the support system for women and the elderly in Bangladesh, Amin concluded that:

In Bangladesh, a strong familial system persists in spite of increasing land impoverishment, rapid fertility decline, the changing pattern of sons departure from their parental households, and a legacy of high population growth (Amin 1998:211).

Prevalence of violence

The stories behind the criminal assault cases in the orthopedic ward tell us about the level of violence and intolerance in the society outside of the ward: one cuts off his relative’s hands to acquire a piece of land, one political group cuts the limbs off of the members of rival political group in order to take revenge, tribal people are engaged in armed struggle to protect their ethnic identity, one attempts to murder his employer for dismissing him from the job, one kicks his neighbour simply because the vines of her bean tree have climbed over his mango tree.

Violence, aggression, murder and blood are persistent themes in Bangladeshi social life. The big red circle in the middle of Bangladeshi flag symbolizes the bloody independence of Bangladesh in 1971 in which more than 300,000 Bangladeshis died. A few decades prior to that, in 1947, during the partition of British India, several thousand people died in Hindu and Muslim religious communal riots, which was mostly concentrated in Bengal (Roy 1994). Sporadic communal riots also continued in Bengal in later decades. After independence, two of the head of states were assassinated, including the leader of the war of independence, Shiekh Mujib. A few more thousand of
people, both soldiers and civilians, were killed in a series of coups and countercoups in the first decade of Bangladesh’s independence (Lifschultz 1979, Mascarenhas 1984, Muniuzzaman 1994). Mascarenhas rightly titled his book about the political history of the country, *Bangladesh: The legacy of blood* (1984). In present day Bangladesh, it is almost impossible for a day to pass without reading news of cases of severe violence and homicides in the country. For last few years violence has been the most heated issue about which political parties are continuing to debate in the parliament.

A UN Report (2000) states that Bangladesh has seen a nearly 40 percent increase in the incidents of crime in the period of 1991-1996. The crimes include assaults on individuals, destruction of property, shootings and homicides. Gender-based violence, which often stems from existing socio-cultural attitudes that regard women as inferior to men, takes place in various forms that include wife beating, rape, acid throwing, trafficking, sexual coercion and harassment, as well as verbal and psychological abuse (Jahan 1994). While there are few reliable statistics on violence against women, newspaper reportage on crimes against women and children indicates that such activities are on the increase. Some 3,123 cases of violence against women (of which 735 were murder cases and 904 were cases of physical torture) were reported between January and August 1996, according to Ministry of Home Affairs (UN Report 2000). Because many incidences escape being reported, the actual number will likely be much higher. Hadi’s study, based on the data from the demographic and health surveillance system of BRAC, reveals that the violent death rate was 28.3 per 100,000 persons per year during 1990-1999 (2002). Homicide tied with drowning as the leading cause of death, and in a country where two-thirds of its land remains submerged in water for nearly a third of the year, death due to drowning is not unusual. The increased number of homicides, however, is. Hadi noted that homicide, particularly the incidences of political killings, has been increasing during the last decade. We may recall how the doctors of the orthopedic ward anticipated the rise of number of violence-related injury cases as the union council (local level government administrative unit) election day was approaching.

Peiris (1998) discussed how since its independence, Bangladeshi politics have been characterized by several types of seemingly endemic conflicts, some of which have been associated with either periodic outbursts of violence or prolonged, relatively low key armed confrontations. Destabilizing external influences, inter-group divergences of interests and aspirations in the country, economic stagnation and persistent poverty were identified as the causes behind these conflicts. One such example is the violent armed uprising in the Chittagong Hill Tracks led by the Chakma people that was caused by the failure of the government to accept plural national identity of the people of Bangladesh (Van Schendel 2001, 2002). Despite rhetorical commitment and
prolonged struggles to establish democracy, the political parties have failed to establish a consensus over the ground rules for democratic competition and dissent. They have relied heavily on money and mastaans (muscle men) to mobilize support and capture votes. Khondker wrote that in Bangladesh, political rulers are similar to a crime syndicate (e.g. the mafia) in their styles of exploitation and extortion (1990). Political competition has degenerated into a deadly confrontation because the stakes of winning or losing control of state power are too high for the personal and political fortunes of the competing leaders and their parties (Jahan 2000). Violence, therefore, has become an integral element of Bangladeshi politics.

Violence generally erupts from conflicts over the exercise of the right to control or acquire resources, especially in a hierarchical situation where such power and/or resources are unequally distributed (Jahan 1994). Frequent eruption of conflict and violence is therefore a common feature in a hierarchical society like Bangladesh, where the inequality of power and resources between individuals and groups is intense. Violence is also a consequence of bad governance by the government of Bangladesh (Barenstein 1994, Khan 2002, Siddiqui 1996). To define governance Barenstein quoted Landell-Mill: ‘Governance is the exercise of political power to manage a nation’s affairs’ (1994:18). He mentioned various contributing factors causing ‘fuzzy’ governance in Bangladesh that includes lack of political commitment, poor organization and management and lack of institutional capacity. Khan (2002) discussed how in the first three decades of Bangladesh’s life, governance remained the central concern in the face of continuing political turbulence, leading to a growing undemocratic political culture and environment. She stated: ‘Effective democratic governance continued to be the elusive “golden deer” that the nation doggedly sought but could not find’ (Khan 2002:107). Thus, because of weak governance, the Bangladeshi government failed to maintain rule in the public domain of the country.

Katalova describes how land disputes are constant phenomena in rural Bangladesh that frequently result in violent combat (1996:124). The violence particularly intensifies during the ploughing season, as it is then that it usually appears that a particular piece of land had been sold to more than one buyer. She described how the local hospitals prepare beforehand for receiving an increased number of injury cases during this seasonal violence. As the season approaches the women of the village lament: ‘Onek rokto hobe’, ‘A lot blood will be shed’. If we combine this observation with the story of the woman in the orthopaedic ward who was kicked in the hip by her neighbour, the thwarted suitor who tried to break his girlfriend’s father’s hand, the muscle men who took money to cut someone’s enemies’ wrists, the two blood-soaked men who walked from the river bank to the highway at midnight after their hands has
been cut and thrown into the river, it tells us that Bangladesh, once a peaceful land of the non-violent Buddha, has become a violent country in recent years.

Invisibility of women

The orthopaedic ward also reflected the gender dimension of the society. The ‘maleness’ of the orthopaedic ward is prominent. Most of the patients are young males, as they are the main work force in Bangladesh and have greater likelihood of becoming victims of orthopaedic injuries. The majority of the attending relatives are also male, which is in contrast to the stereotype that women are caregivers, but is indicative of the fact that women have restricted mobility in public places. The majority of the staff members are also male. There are fewer female doctors in Bangladesh than male doctors, moreover, the female doctors feel discouraged from becoming involved in orthopaedic medical practice as they think it demands more physical strength. In addition, it is easier for the male staff members to discipline the unruly, confused mass of the ward. The female nurses, the only prominent women actors in the ward, again suffer from gender-based discriminatory views in which they are looked down upon because of the public nature of their work. They must stay outside of home at night in the company of male colleagues, which is considered to be a breach of Islamic moral conduct for women.

This relative invisibility of women in the public sphere is a characteristic feature of Bangladeshi society. To a great extent this is related to the Islamic notion of purdah. Literally purdah means ‘curtain’ or ‘veil’. It refers to the system of isolation of Muslim women from outsiders and the imposition of high standards of female modesty. It is a complex institution that entails much more than restriction on women’s physical mobility. It means more than wearing burkha (a long dress covering all parts of the body). It is the internalisation of values of shyness, timidity, honour and shame (Begum 1987:11). Purdah is observed in some form or other by most rural and urban women. Purdah is considered a symbol of respectability. However, strictness in the observance of purdah varies with age and marital and social status of women. Although all veiled women are not passive victims as assumed by many Western feminists (Mohanty 1988) and although the practice of putting women in purdah is changing, it is still socially valued in Bangladesh. The ideology of purdah serves to sanction and legitimate the separate and unequal worlds of women. It inhibits women from directly participating in activities carried out in public sphere. Katalova observed:

The most striking characteristic of the agnatic emphasis in Bengali Muslim culture is that half of its population [46% of Bangladeshi population are women] those who retain an eminent role as life
sustainers are defined by their absence. Unless thoroughly concealed, women are not to be seen at public events, in the street or on public transport (Katalova 1996:16).

Khan insightfully discussed the issue of limited public life of Bangladeshi women. She argued:

In Bangladesh, women’s public life is restricted due to the state maintenance of male control over the ‘power stations’ of politics, industry, armed forces and religion. The society is patriarchal and state laws and policies and the way the legal system is run all reflect this attitude (Khan 2001:12).

As a result, the state of women is much poorer than men in Bangladesh in respect to employment, education, health and legal rights (Khan 2001). Although male domination and female subordination in varying degrees is still a universal phenomenon, a number of ethnographic accounts show its intense nature in Bangladesh (Arens & Beurden 1980, Blanchet 1984, Gardner 1991, Hartman & Boyce 1983, Katalova 1996, White 1992). Gardner wrote that one of the first things she was told in a Bangladeshi village was: ‘Women’s heaven is at their husbands feet’ (1999:56). She observed that women are denied entry to all male domains (the mosque, the market, the fields and the village council). Many of the married women whom she knew were nameless, labelled through their relationships to men, as so-and-so’s wife or so-and-so’s mother. Katalova (1996) described how Bengali Muslim women’s sense of ‘belonging to others’ grows. Blanchet talked about ‘women’s subculture’, for behind their purdah, in their polluted state as female, wives or mothers, women do not experience the world the way man do (1984:17).

Bangladeshi urban middle class women, who comprise only a small portion of the population, enjoy relatively greater freedom. They pursue higher education, hold various professional jobs and even join non-traditional occupations for female like armed forces or aviation, albeit in fewer numbers than men do. Changes have also taken place in recent years in the life of rural poor women due to various developmental activities of NGOs. Targeting women as their primary recipients, NGOs have provided credit programs and training that have contributed to a decline in fertility, increase in income and the appearance of institutional settings that have brought women together for collective discussion and exchange (Feldman 2002, Khan 2001). On the other hand, a remarkable change has also taken place in the life of the urban poor women through their employment in the rising garment manufacturing industries in different cities of Bangladesh. Abdullah mentioned how in the late 1980s people in the cities of Bangladesh, whose public places were notoriously
devoid of feminine traffic, suddenly had to accustom themselves to the sight of rapidly increasing numbers of young women walking to and from work everyday (2002:138). The number of working women is insignificant in comparison to the vast numbers of women in the country who still live a secluded life. Abdullah mentioned that according to the 1990-91 Labour Force Survey, in contrast to the 6.48 million men, only 773,000 women were employed in various service sectors in the urban areas. The significant majority of both urban and rural Bangladeshi women therefore live a life that is restricted through various patriarchal values and norms. The invisibility of women in the public sphere is still the characteristic feature of Bangladeshi society. As Mohammad Yunus, the founder of the internationally renowned Grameen Bank, a bank for the poor, once commented: ‘Bangladeshi women are like the other half of the moon, we know it is there but do not know much about it’ (in Khan 2001:12).

The orthopaedic ward, a public place that deals with the medical problems that result mainly from exposure to dangers occurring in public places, is therefore occupied predominantly with males. Female patients are relatively invisible, much like the other side of the moon.

**Dwindling public morality**

The behaviour of the actors in the orthopaedic ward showed a general low sense of public morality. The lower level staff steal medical and non-medical items from the hospital and the drug shops outside the hospital buy the stolen items for low price. The lower level staff also take *bakshees* (tips) from the patients for the services they are obliged to give per their job description. The patients and their relatives also sometimes steal or destroy hospital property. Patients are least bothered about the cleanliness of the ward or hospital. The stories of the patients who are victims of road traffic accidents show clear tendencies of non-compliance with the country’s traffic and motor vehicle laws. The doctors leave the hospital long before their office hours should end, to engage in lucrative private practice. Greater importance is given to group interests rather than institutional interests, and frequent strikes are called by various groups of staff that destabilise the hospital. Administrative personnel take bribes from the employees in exchange of transfer and deployment to more favourable places and positions.

Such unethical behaviour is again a feature of broader Bangladeshi society. The rise of crime and corruption in public life has continuously been an issue of discussion among everyday citizens and intellectuals since the independence of Bangladesh. The Bengali proverb, ‘Ovabe shovab nosto’, ‘Poverty breeds immorality’ is a simple answer to this problem. However, there are many more dimensions to this problem. Twenty years ago, Farouk cited the
following reasons for the general decline of public morality in Bangladesh:
political instability, potential for making windfall profits instead of building up
solid enterprises and lack of political will to deal with corruption (1982).
Although some form of corruption was always present in the government and
politics, it took a colossal shape after independence. Foreign aid became the
prime source of corruption of the country (Lifschultz 1979:40). In the two and
a half years after independence, Bangladesh received more aid than it had
received in its previous 23 years as a province in East Pakistan. Nearly 2 billion
USD worth of relief in commodities, aid, contracts and international business
poured in from overseas countries. But there was huge misappropriation of
these relief items. Hartmann and Boyce, who were doing an ethnographic study
in a Bangladeshi village during that period, recounted an interesting note in this
regard. They mentioned that people often told them after the 1971 war, 90
million blankets had come to Bangladesh for 75 million people, but the only
person they knew who had received one was the landlord (1983:6). ‘Where is
mine?’ they asked.

Independence rid the country of the old dominant ashraf merchant
class that consisted mainly of Pakistani Muslim Bhairis and Hindus who were
left over from British days. A new business class could grow from the non-
ashraf (noble) native Bangladeshi’s for whom business was not a traditional
occupation. Unlike old ashraf businessmen, this new class was interested only
in money, did not bother about prestige or morality and too readily used its
management skills for nefarious purposes, such as bribing government officials
for business contacts that once automatically went to the ashraf elite. With the
extraordinary sum of foreign aid involved, talk of ‘black money’ and stories of
illicit trade deals became part of the dark new folklore of the post-
independence period. Alam (1995) argued that due to double colonial rule by
the British and the Pakistanis, the polar classes in Bangladesh i.e.
bourgeoisie/landlords and workers, remain structurally underdeveloped. In that
condition of underdevelopment, a petty bourgeois political organization, the
Awami League, became the dominant historical force that led the war of
independence. After independence, the Awami league failed to uphold the
promises it had made to the masses, and instead engaged in petty bourgeois
opportunism. Various corrupt practices spread among all levels of the society.
Mujib, the leader of the party and ‘father of the nation’ was ultimately
assassinated in a military coup despite his unsuccessful measures to control the
nation-wide corruption. Successive military rulers, because of their weak
political base in the society, had to provide various undeserved advantages and
illegitimate benefits to a multitude of professionals to gain their support.

Public corruption gradually became institutionalised. The people’s
hopes for a free, just, prosperous society were never fulfilled. People became
disillusioned about state and politics. The entire premise of twentieth-century
Bangladeshi thought, as taught in schools, in universities and editorialised about in newspapers has been the centrality of government and politics as the solution to humanity’s problems. This belief in the importance of the state has been the central doctrine of intellectuals as well as the general masses. But thus far, the state failed to solve humanity’s problems. Here again the issue of bad and ‘fuzzy’ governance of Bangladesh emerges (Barenstein 1994, Khan 2002, Siddiqui 1996). Siddiqui discussed the irony of how corrupt even the Bureau of Anti-Corruption (BAC) of the Bangladesh government was, and how it needs to be completely reorganized (1996:24). People therefore see that the state functions to benefit only a few. The idealism and patriotism with which the people fought independence war has died. They have lost faith in government and citizens have developed a general disrespect for anything that is public. The popular saying in Bangladesh, ‘Shorkar ka mal doria me dhal’ ‘Government property? Throw it in the river!’ reflects this mindset.

Wood (1994) has argued that any discussion of corruption has to include the problematic nature of the state and market. For some, corruption only refers to the misuse of public funds. Others, however, find corruption in amoral markets in which transactions are not transparent. He noted that in societies like Bangladesh, the scale of intervention by the state in the economy and the society is extensive:

The defaulting state, unable to control markets and [is] itself thereby marketised. The space has been created, room for manoeuvre as it were, within which both public and private predators flourish with interchangeable roles (Wood 1994: 530).

He further argued that he does not dismiss ‘corruption’ in Bangladesh as pathological or deviant. As he pointed out, the central concern throughout the development administration has been the appropriateness of bureaucracy to make and implement allocative decisions under prevailing conditions of extreme scarcity and in the context of a weak general market. He argued that:

A persistent analytic weakness has been to judge the performance and behaviour of officials and institutional formulæ by criteria which lie outside the social structure and culture of the society in question, derived from some model of Weberian rationality. It has rarely been acknowledged that any achievement of instrumental, objective behaviour on the part of the officials in the West has been based upon the granting of privilege, status and personal resources to the point where their separation from prevailing but imperfect market cultures has in effect been purchased on their behalf by the state, removing the
necessity, as it were, for individuals to purchase such security directly (Wood 1994: 520).

Bhadra and Bhadra even questioned the moral aspect of corruption. They argued that the institutes of Bangladesh in the context of free market economy are neither moral nor immoral: they are reactive (1997:74). They mentioned Osterfeld (1992) who divided corruption into ‘expansive corruption’ and ‘restrictive corruption’. Corrupt acts that move the economy in the direction of the free market are expansive; they extend opportunities for mutually beneficial exchange. Bribes for licenses or services are examples of such expansive corruption. The presence of ‘black market’ and ‘back doors’ for certain goods and services represent ingenious attempts to circumvent often illogical and almost always costly regulations. Restrictive corruption, on the other hand, reduces the potential for economically beneficial exchanges. It is usually a zero- or even negative-sum game, consisting of wealth transfers. Straightforward cases of embezzlement, for example, represent a transfer of funds from public to public officials. The authors therefore pleaded for intervening in restrictive corruption.

Maloney drew attention to the pragmatic individualistic behaviour of Bangladeshis while discussing their public morality (1986:51). He argued that Bangladeshis could be said to be individualistic in the sense that they are pragmatic and opportunistic in their behaviour. The term ‘individualism’ here is not defined as the individualism that has evolved in European history, which implies intellectual freedom, voting and other human rights. The Bengali is an individualistic in the sense that he behaves atomistically to maximize opportunity through social relations, learns to find his own way in life and does not depend much on government’s institutions or ideologies. He does not give much weight to abstract rules laid down by some bureaucracy nor to the ideology of any authority, but rather to reality of dyadic human relations. Maloney wrote:

Bengali English has given ‘sincere’ a unique shade of meaning. It is often stated that someone is ‘not sincere’. The implication may be lost to someone who has not observed that the majority of employees in bureaucracies in fact are not sincere in really working for the abstract goals of the organization. They are scarcely motivated by the social environment of the bureaucracy. Much of the energy of such employment goes into just socializing, protecting themselves in the hierarchy, or arranging some scheme for personal advantage (...) Now if this sounds judgmental against Bengali society, according to contemporary values, it should be remembered that over the history of
millennia the judgment might be reversed, and Bengali society might endure precisely because of these qualities (Maloney 1986:52).

The ‘insincerity’ of the staff of the orthopaedic ward and the disrespect for public property by the patients and relatives could therefore be seen as the combined manifestations of the general disillusionment of people with the government, the problem of state and market, the ‘expansive’ or ‘restrictive’ corruption of free market economy, or as a pragmatic individualism of Bengali personality.

Inventiveness

The orthopaedic ward displays how people adjust and find inventive ways to cope with various constraints of everyday life. To combat limited resources, the doctors invented cheap, locally available options to manage orthopedic cases. They have also developed various alternative measures to solve administrative problems, like extracting money from rich clients and pharmaceutical companies or recruiting unofficial staff. They also maintain dual jobs in order to cope with their low government incomes. The other actors in the ward have similarly developed their own survival techniques. In the context of manpower shortages, the relatives of the patients have made themselves an informal partner in the hospital organization. The poorly paid lower level staff formed associations to protect themselves from being accused of committing illegal acts to enhance their income. The patients resisted the domination of medical authority through subversion of discipline, humour and by rejecting hospital care. The orthopaedic ward thus shows how people change the formal rules and actively adjust to the local environment.

Various authors have observed the coping mechanisms and inventiveness of Bangladeshi people when faced with a lack of resources and institutional support. When Bangladesh achieved independence from Pakistan in 1971 and was recognised by the whole world as a sovereign state, the first question asked was: Could it survive? Many development pundits expressed serious doubts about the country’s capacity for self-rule and self-development as an independent state. Bangladesh was referred to as a ‘test case of development’ (Faaland & Parkinson 1975). That basic question has now been answered: Bangladesh has survived its first three decades. Despite repeated disasters, political instability and poverty, the people of Bangladesh have found their own survival techniques and also made considerable progress in many sectors, and in the meanwhile disproved conventional assumptions of development scholars.

Streefland discussed the significance of mutual support arrangements for the coping, consolidation and emancipation needs of the poor in
Bangladesh (1996). Jensen showed how the actual lack of resources caused people to adjust their relationships to each other in a special way, thereby shaping the social patterns that dominate in rural Bangladesh (1999). Westergaard and Hossain (2002), who visited the same village in northern Bangladesh at two different points, in mid-1970s and mid-1990s, found that in the course of three decades, the poor, stagnant village had learned how to live better on less land, through various agricultural changes and through income from non-agricultural sources. The Bangladesh human development report similarly pointed out that based on the Bangladeshi experience, it can be said that higher social and human development outcomes can be achieved even with a low per capita national income (BIDS 2001). Sen (2002) showed how Bangladesh has come a long way; it defied the predictions of the development pundits and became a lead performer among the ‘least developed countries’. Alam (1995) and Sobhan (2002) discussed the growth and potential of ‘civil society’ in Bangladesh, which they consider an indigenous asset that can combat the hegemonic crisis in Bangladesh politics. Maloney believed in the adaptive function of many Bangladeshi behaviour and social tendencies. He wrote:

Bangladeshi qualities, such as the subtle and intense network of interpersonal relations, the morality of obligations through patronage, and the high attainment of verbal expressive culture, are likely to endure longer than industrialisation, and might prove to be saving qualities (Maloney 1986:68).

Likewise, the various coping mechanisms of the actors of the orthopaedic ward tell us about the inventiveness of Bangladeshi’s nature. As Novak wrote:

They [first time visitors to Bangladesh] were expecting poverty, degradation, and hopelessness, as most television news shows and aid agency advertisements focus on the poor, who generally are portrayed as passive victims of floods or worse. But Bangladeshis are anything but passive sufferers. They are doers. (Novak 1994:18).

When I stated the goal of my research, I argued that a hospital ward is not an end in itself, but that it can mirror various features of the life of the country of which it is a part. Through the experiences of various actors of the orthopaedic ward, I see a Bangladeshi society that is poor, hierarchical, family-oriented, male-dominated, morally weak and violent, yet adaptive and inventive as well. As I stated in the introduction, this is a middle class, Bangladeshi, male, public health oriented physician who is looking in the mirror. There are bound to be distortions and cracks in my view.