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

Zaman, S.

Citation for published version (APA):
Chapter XI

CONCLUSION: BROKEN LIMBS, BROKEN LIVES

This book is the result of ethnographic research that I did in an orthopaedic ward of a government teaching hospital in Bangladesh. The research had two major goals: first, to depict various social and cultural dimensions in the life of a Bangladeshi hospital, and thus demonstrate the local nature of biomedical practice and second, to illustrate how the values and norms of Bangladeshi society become expressed in the hospital life.

With a few notable exceptions, the social and cultural studies of hospitals have focused largely on American and European hospitals, ignoring the hospital culture of non-Western countries. Although biomedicine is fostered through an international political economy of biotechnology and by an international community of medical educators and bioscientists, it is taught, practiced, organized and consumed in a local context (DelVecchio Good 1995). With this description of life in a hospital ward, I have shown the distinctive cultural character of biomedical practice in a non-Western country: Bangladesh.

Although there is a typical biological reality in the hospital that makes it a cosmopolitan biomedical institute, I have shown how the social dynamics necessary to deal with that reality give hospital life a local character. To portray the local character of the hospital life, I have depicted the actions, ideas and concerns of different actors of the orthopaedic ward of a Bangladeshi government teaching hospital. As this is the cheapest option for tertiary level treatment, the hospital is occupied chiefly with patients from lower economic background. The poor patients, mostly young males who are victims of road traffic accidents, criminal violence and poor occupational safety, are damaged socially, economically and mentally through the hospitalisation, even though they may improve physically after hospitalisation. Though the admission charge in a government hospital is nominal, there are costs involved in buying essential medicines and materials, as there is insufficient hospital supply, as well as costs due to various informal payments in the form of tips to the lower level staff. The poor patients thus become economically ruined due to hospitalisation. The patients, far from featuring at the apex of the hierarchy, are incorporated into the hospital world at a level lower than any hospital staff. There is hardly any practice of communicating medical information to the patients and almost no attention is paid to the patient’s need for privacy or other ethical issues. Instead, they are constantly humiliated and abused by all level of staff for any breach of conduct. The patients, though do not overtly challenge the medical domination like their Western counterparts have begun
to do, try to maximize their opportunities in the hospital and maintain their dignity in various covert ways. Relatives of the patients, unlike in Western hospitals, become an informal but integral part of hospital organization. Due to severe shortage of staff, relatives take on virtually all the nursing responsibilities of the patient. They also provide economic and emotional supports to the patient as well as play an intermediary role between patient and the staff. The staff reluctantly relies on the essential support of the family members, yet humiliate and abuse them in the similar manner they do to the patients. Ironically, even though the relatives are healthy, they experience all sorts of trouble in the course of hospitalisation. The patients and their relatives are the vulnerable clients of the hospital and must face the dominant world of hospital staff.

Powerful hospital staff, though united from outside are divided within. The ward boys, cleaners and gatekeepers, referred to as Class IV employees, are at the lowest level of the hospital staff hierarchy. They are, however, more powerful than the patients and their relatives because of their affiliation and experiences with the hospital. The poor patients rely on lower level staffs to seek favour for their various day-to-day necessities in the hospital, as they are socially closer to them than to the doctors or nurses. The lower staff are indispensable to higher level staff too, as they do all sorts of manual work that is necessary for the everyday functioning of the ward, and doctors and nurses can delegate various unprestigious tasks to them. The low-paid lower staff exploit their indispensable position for economic gain. They demand tips from the patients in exchange for services offered. They increase their income by other ingenious ways, like stealing patients’ or hospital property. They dismiss any action taken by the hospital authority against their crimes by organizing strikes through the Class IV employees’ association. Despite their inferior position, they are quite influential in the hospital world, unlike employees of their level are at hospitals in other part of the world.

The role and image of Bangladeshi nurses have become altered and is now far from the ideal image of nursing. Bangladeshi nurses do little actual nursing of the patients. They are mainly occupied with taking care of the files, registers, records and equipment in the ward. It is impossible for the limited number of nurses on duty to attend all the patients, and besides, doing paper works bring them some prestige, which is diluted if they mix too much with the public. According to Hindu values, because nurses carry out ‘dirty manual work’ they are associated with lower caste. For Muslims, the public nature of nurses’ work is considered morally demeaning for women. The Bangladeshi nurses, therefore, do not fit with the ideal image of loving, self-sacrificing, noble ‘ladies with lamps’.

Doctors, on the other hand, exert their control over the ward through a display of pride, intellectual arrogance and a sense of hierarchy. The space and
resource allocation for them in the ward and their widespread practice of scolding the patients, their relatives and lower staff demonstrate their superiority. However, in spite of their control and authority over the ward, Bangladeshi doctors are also highly frustrated. They are deeply unsatisfied with their work environment, where they have to work with extreme scarcity of resources and with insufficient manpower. They are also frustrated by their low governmental salary and the growing negative image of the medical profession in the society. To cope with the situation, the doctors sometimes bypass formal biomedical ways of treatment and use various local ways to deal with orthopaedic problems. They have also developed informal means to deal with administrative constraints. They maintain dual jobs and become engaged in private practice in order to increase their income. Although the sense of pride and hierarchy is considered to be a characteristic of biomedical physicians across the world, its forceful nature, combined with the frustrations and coping strategies of the doctors in the orthopaedic ward, are unique to Bangladesh. Thus, the role, status and image of Bangladeshi medical personnel, along with the patients and their relatives and the way they interact in a hospital setting demonstrate the distinct nature of biomedical practice in a non-Western setting, Bangladesh.

The second aim of the study was to illustrate that the ethnographic description of a hospital culture reflects the values and norms of the broader society in which the hospital is situated. The value of early hospital ethnographies done in the 1960s and 1970s lies in the fact that they first demonstrated the presence of a distinct social world within the hospital created by the patients and documented the complex set of relationships between patients and the staff. They also discovered a collective experience of illness and hospitalisation. But in those ethnographies, the authors considered hospital life as an end in itself and as an isolated subculture. They discussed how sick people are taken out from a normal society and put in a hospital that is like an island. Other relatively recent hospital ethnographies also focused mainly on medical discourses and attempted to identify the culture of biomedicine; they too did not pay much attention to the link between hospital life and the life of the society outside the hospital in which the hospital is nevertheless situated. In contrast, my emphasis was that a hospital is not an isolated subculture, but rather it is a microcosm of the larger culture of which it is a part. I have discussed how the life and experiences of different actors of orthopaedic ward of Chittagong Medical College Hospital actually mirror various social, cultural, economic and political characteristics of the wider Bangladeshi society.

The budget deficiency and the scarcity of medicine, material and manpower in the hospital reflect the overall poverty of Bangladesh, which is one of the poorest countries of the world. I have mentioned the various meaning of the word ‘poverty’ in Bangladesh as used by the government,
opposition political parties, development agencies, journalists and by people in
general. I have discussed how external factors like wealth depletion by colonial
powers and natural disasters like floods, droughts, cyclones and lack of natural
resources, as well as internal factors like heavy population and population
growth, illiteracy, high morbidity and mortality, low industrialisation, political
instability and inequitable distribution of income and social opportunities have
caused the poverty in Bangladesh.

The life within the hospital ward also showed the value of social
hierarchy, which is a distinctive feature of Bangladeshi culture; Bangladeshis
are remarkably preoccupied with social status and rank. The utilization of
space, facilities, language, gestures and behaviour of the staff and patients
display who is ‘big’ and who is ‘little’ in the ward. The doctors are perched at
the top of the hierarchy, while patients fall at the bottom of it. I have discussed
how this sense and practice of social hierarchy resulted from three factors:
economic class division of a society in which there is extreme inequality of
power, influence and opportunity; childhood upbringing in which people
experience themselves in subordinate-superior relationship; and the lower
prestige that is associated with manual labour, which is related to religious
beliefs concerning purity and pollution.

The crucial role of relatives of the patients in the ward reflects the
value of families in an individual’s life in the Bangladeshi context. Bangladesh
is a society in which people are organized mainly through primary relations
and family is a strong social institute that plays a very significant role in
various aspects of individual’s life, including his/her therapy management. I
have discussed how due to the absence of alternative institutional social
networks, family has persisted to be the main source of support during crisis
situations.

The stories behind the criminal assault cases in the orthopaedic ward
show the level of violence in Bangladeshi society. Aggression, murder and
bloodshed have been persistently present in Bangladeshi social life.
Historically, Bangladesh has experienced violence through war, riot, coup and
countercoups. The conflicts arising over right to control or acquire resources
frequently become violent in Bangladesh as the inequality of power and
resource between individuals and groups is intense in the country. I have
discussed how various destabilizing external influences, including inter-group
divergences of interests and aspirations in the country, economic stagnation
and persistent poverty, patriarchal values as well as bad governance cause the
violent conflicts.

The relative absence of females in the ward indicates the invisibility of
women in the public sphere in Bangladeshi society. Most of the patients are
young males; the majority of the attending relatives are male. As males are the
main work force in Bangladesh, therefore they are the main victims of
orthopaedic problems, and as the orthopedic ward is a public place, women are reluctant to take their traditional role as caregivers in a hospital setting. The doctors, too, are predominantly male; there are fewer female medical professionals than males in Bangladesh, moreover the physical demands and frequent interaction with the public in orthopedic practice discourages female doctors from becoming involved in orthopedic practice. I have explained how this relative invisibility of women in the public sphere is a characteristic feature of Bangladeshi society that is related to the Islamic notion of purdah, which refers to the system of isolation of Muslim women from outsiders and the imposition of high standards of female modesty. This notion of female seclusion has resulted in poorer state of women than men in Bangladesh in respect to employment, education, health and legal rights.

A general low sense of morality was also expressed by the behaviour of the people in the orthopaedic ward: the theft of hospital property by the lower level staff and the patients and their relatives, bribes taken by the administrative personnel, the disregard of official rules and frequent strikes that destabilized the hospital reflected the priority of staff interests over that of patients’ well-being. This corruption and lack of morality were linked to political instability, lack of political commitment, general disillusionment with the state, the problem of state and market, the nature of free market economy, weak governance and the pragmatic individualism of Bengali personality.

These images of poverty, robust hierarchy, absence of organized support system for individuals, relative lack of empowerment of women and widespread corruption give a gloomy picture of a society. The national anthem of Bangladesh celebrates a ‘Sonar Bangla’ (Golden Bengal), the vision that mobilized the people during the independence war of Bangladesh in 1971. In people’s mind there was the vision of a society that is economically prosperous, free of exploitation, democratically governed and respectful of people’s rights. That vision has been shattered by a multitude of internal and external forces. The lives of Bangladeshi people, and its society at present is apparently ‘broken’. Within the miniature world of ‘broken limbs’ one can experience the ‘broken lives’, individual lives of the people concern, as well as collective life of the society in general. Yet I have always been uncomfortable with my title of this book. Someone inside me is reluctant to call Bangladeshi society and lives of its people ‘broken’. This may be a problem of being a native of Bangladeshi culture. This probably is an aspect of suffering of lost pride in Bangladeshi mind, and probably the manifestation of post-colonial self. (Nandy 1983).

The ethnographic account also explains how ‘brokenness’ is not the essence of Bangladeshi society. The actors of the hospital showed their remarkably inventive capabilities for adapting to seemingly impossible circumstances, as have Bangladeshi citizens throughout the country. The
society might be apparently broken, but it did not fall part. The members are trying to hold it in its position. They are changing and adjusting. Through the suffering of change and innate adaptive quality of Bengali people, Bangladesh is challenging its great hardships. About two hundred years after the French Revolution the great revolutionary Zhou En Lai was asked to comment about the significance of the Revolution. He is reported to have answered: ‘It is too soon to tell’ (Khan 2001:156). Three decades is too short a span of time to assess the significance of the liberation movement of Bangladesh. I therefore cannot help but be optimistic about the vision of ‘Sonar Bangla’. As Joan Robinson said:

‘Anyone who writes a book, however gloomy its message may be, is necessarily an optimist. If the pessimists really believed what they wrote, they would have no point in saying it’ (O’Donnell 1984:269).