



**"I Can't Tell You All My Troubles": Conflict, Resistance, and
Metacommunication in Bangladeshi Illness Interactions**

James M. Wilce, Jr.

American Ethnologist, Vol. 22, No. 4. (Nov., 1995), pp. 927-952.

Stable URL:

<http://links.jstor.org/sici?sici=0094-0496%28199511%2922%3A4%3C927%3A%22CTYAM%3E2.0.CO%3B2-9>

American Ethnologist is currently published by American Anthropological Association.

Your use of the JSTOR archive indicates your acceptance of JSTOR's Terms and Conditions of Use, available at <http://www.jstor.org/about/terms.html>. JSTOR's Terms and Conditions of Use provides, in part, that unless you have obtained prior permission, you may not download an entire issue of a journal or multiple copies of articles, and you may use content in the JSTOR archive only for your personal, non-commercial use.

Please contact the publisher regarding any further use of this work. Publisher contact information may be obtained at <http://www.jstor.org/journals/anthro.html>.

Each copy of any part of a JSTOR transmission must contain the same copyright notice that appears on the screen or printed page of such transmission.

JSTOR is an independent not-for-profit organization dedicated to creating and preserving a digital archive of scholarly journals. For more information regarding JSTOR, please contact support@jstor.org.

“I can’t tell you all my troubles”: conflict, resistance, and metacommunication in Bangladeshi illness interactions

JAMES M. WILCE JR.—Northern Arizona University

Months after falling from the rafters above her single-room house, Yasmin came to Ali, an Ayurvedic *kabirāj* (traditional healer)¹ and maker of herbal remedies. She complained of sleeplessness, loss of appetite—and a growing “tumor” near the site of her fractured collarbone. She had already visited many other practitioners and had an X ray taken at a government hospital; they reportedly found evidence of a fracture, ulcers, and cancer. Her husband’s resources exhausted, Yasmin had turned to her brother. He had brought her to Ali and would pay the expenses. Ali listened to Yasmin and her brother telling her troubles at some length. About five minutes into the consultation, Yasmin turned to a new facet of her trouble, asserting, “I haven’t yet told you; I haven’t told the half of it yet!” A bit later as Yasmin began to express despair, Ali cut her off; before she could finish saying, “My life is beginning to be erased,” he stepped in to ask, “Then your appetite and thirst are weak?”

In this article I explore a pattern in Bangladeshi medicine in which the right to tell one’s own troubles is contested and accommodation between patients and their interlocutors is tenuous. My findings illustrate the claim that “discourse is not simply talk about conflict and accommodation—it *embodies* them” (Briggs 1992:356; emphasis in original). I stake out common ground between linguistic and medical anthropology as I demonstrate how illness interactions reflect and construct relations between patients, kin, and practitioners in their sociocultural context.² More specifically, I make three major interrelated points. First, illness interactions in the rural Matlab area of Bangladesh are often adversarial, as they can be in Western countries. Patients’ talk disturbs and moves others. It may point to conflict external to the “medical situation” as much as it points to “symptoms.” But medical encounters themselves always involve negotiation and often fail to resolve discord. Conflict internal to Matlab medical encounters centers not only on explanatory models of the illness but also on the right to speak (cf. Lazarus 1988). Both kin and practitioners often prevent the sick person from telling what is the matter. Even if the patient can express the problem, fresh contention arises over its implications. Conflicts that appear specific to a given case or set of actors reflect broader patterns of social relations in Bangladesh as they also reflect the global flow of ideas, products, and power.

Transcripts of interactions between patients, kin, and healers open up the lives of four rogī (“sick ones” or “patients”) in Matlab, Bangladesh. I compare the pattern of domination and resistance in those interactions with Western biomedical encounters. Patients in Matlab express dissatisfaction with the power relations of family or medicine through low-level means that do not enter discursive consciousness. By indirectly calling attention to the suppression of their voices, patients’ metacomplaints—a species of metacommunication evident in two of the interactions—entail an incipient cultural criticism. [metacommunication, medical interaction, gender hierarchy, social labeling, ideology, Bangladesh, South Asia]

American Ethnologist 22(4):927–952. Copyright © 1995, American Anthropological Association.

The second point I make is that critical sociolinguistic analyses of medical relationships, particularly practitioner-patient communication, should be extended to traditional-medical settings in poor countries. Some explorations of Western medical encounters have focused on the conversational enactment of power, but fine-grained discourse analysis has been consistently lacking from the ethnography of non-Western medical encounters.³ Aside from Frake (1964) few scholars have applied linguistic tools to non-Western medical events. This division of the world and of academic labor creates the impression that only Western patients speak powerfully and only non-Western practitioners act symbolically. I describe here how Matlab patients clash with kabirāj but especially with family members and *ḍaktārs* (local practitioners of biomedicine). Although some traditional practitioners in Matlab allow patients more time to develop their stories than do their biomedical counterparts, kabirāj Ali cut his patient off at the most sensitive point of her narration. Thus we find cases across a spectrum of Bangladeshi medical encounters in which patients struggle to find their voices or make them heard.

Third, I stress that Bangladeshi “patients” (*rogī*, literally, “those with illness”)—like other Bangladeshis—are not passive before powerful individuals (practitioners, males, etc.) but engage them, challenging or setting limits to their dominance. Through their complaints (“Something is wrong”) and metacomplaints (“I can’t tell you my troubles”), some patients bring social contradictions to light. “Patients,” both in functionalist grammar (where the term may substitute for “semantic direct objects”) and in medical encounters, are objects of the actions of other agents. Patients may indeed be dominated in the social relations of medicine, but they take active roles in conflict nonetheless. By highlighting the agency of patients in Bangladesh,⁴ my analysis contributes to the literature on “resistance in everyday social relations in South Asia” (Haynes and Prakash 1991).

Four transcripts illustrate these arguments. The fact that three of the four selected patients are women reflects their overrepresentation in the ranks of the silenced, the interrupted, and the misconstrued. The four patients saw three practitioners. Kin participated in three of the recorded encounters. My field assistant and I remained present while making video or audio recordings of some 50 “patients”—patients by self-description, reputation, or treatment seeking. I have transcribed all or part of 20 long medical interactions. A larger corpus of speech events—somatic complaints, psychosocial complaints or laments, and folk-medical interviews—was transcribed without the benefit of mechanical recording. Those whom I present have difficulty with their “troubles talk” (Jefferson 1980, 1981). Several in the corpus called attention to that snag in the communication of some other problem, some primary-level complaint. I present two such patients here who make what I call “metacomplaints,” pointing to higher-level trouble affecting a troubles-complaint. Like fissures appearing after an earthquake, communicative troubles betray social-structural fault lines. Although defensive and repressive reactions from listeners may inhibit a full expression of their complaints, they do not always silence sufferers but may in fact occasion metacomplaints. Metacomplaints, exemplifying the reflexive capacities of actors and of language itself, construct theoretical understandings of medical encounters useful to patients and to us.

Presenting primary-level complaints to practitioners appears high on the job description of patients. There has been much discussion—at least among social scientists of medicine and psychiatry—of how those complaints correspond to illness and disease (Good and Good 1981; Rich et al. 1987; Waitzkin 1991; Ware 1992; Waxler 1980). Biomedicine treats pathologies as objective entities and complaints as one audible sign along the road to diagnosis to be balanced by “objective”—often visible—test results. Physicians do not assume a simple correspondence between “presenting complaints” and the pathology to be diagnosed; this is especially true of psychiatrists. There is nonetheless a naive realism inherent in biomedicine’s reification of complaints as well as of disease entities. When complaining is objectified as complaints/symptoms, complaining as an interactive process is lost from sight. A review of the literature analyzing

such discourse processes in Western medical settings provides a lens through which to view the Bangladeshi data.

the right to speak, label, and interpret in medical encounters

From the literature on medical discourse in Western societies, it is clear that patients, practitioners, and researchers in different disciplines only partially agree on the significance of patients' speech and practitioner-patient interaction. Both popular and expert discourses in the West treat patients' speech as a source of important clues to disease or illness. But patients' reports do not always lead directly to a diagnosis in biomedicine; some may be considered misleading. Evaluations of complaints by doctors and lay observers alike evince this ideology of patients' language through terms like "malingering," "getting attention," and "just stress." Doctors depend on patients to give some account of their troubles. Yet as biomedicine has increasingly attended to visible signs produced by instruments, the long-term trend has been to relegate patients' narratives to a lower order of certainty (Reiser 1978). The strongly technological orientation of biomedicine reflects the dominant ideology of Western capitalist societies (Mishler 1984) and typically neglects broader issues of the meanings of illness in patients' lives.

A psychological medicine that attends to a broad range of patients' communicative cues offers itself as a humane alternative to bioscientific reductionism. And for some patients, hearing a doctor explain that their symptom-presentation simply manifests stress can be a relief. They may say, "Oh, then there's nothing seriously wrong." In other cases, by separating manifest content of presenting symptoms from their latent meanings, even the hermeneutical component of biomedical diagnostic practice can devalue patients' words.⁵ This practice may involve listening to but eventually dismissing patients' own accounts and interpretations. Understandably, some patients object to medical reinterpretations of their accounts. Western psychiatry considers the complaints of "somatizers" deviant in their frequency or their vague connection to the organic. Even if practitioners do not use terms like *somatization* or *hysteria* in their presence, some patients are painfully aware of having their symptom-accounts treated as somatization. Patients diagnosed with chronic pain (Kleinman 1992) or "chronic fatigue syndrome" may vocally resist the delegitimation of their subjective experience. Ware describes their sense of being labeled neurotic: "Of the various forms of suffering that experiences of delegitimation can engender, none was as devastating . . . as the humiliation that resulted from having their subjective perceptions and sensations of illness either trivialized or dismissed as psychosomatic" (1992:353). Stigmatizing labels can only add to suffering, and social labeling theory has long argued that they also adversely affect illness careers (Waxler 1980).

If biomedicine is at best ambivalent toward patients' speech, it is not surprising that doctors interrupt their patients. In the speech economy of doctor-patient relations, metacommunicative privileges such as the right to assign labels or evaluate processes are typically held by the doctor. Conversation analysis holds talk to be governed by turn-taking rules; attuned to the actions of copresent others, conversationalists cooperatively produce order and meaning. Interruptions stand out as potential examples of conversational noncooperation; but interruption must be distinguished from benign overlap. Both would seem to be violations of unspoken turn-taking rules. Upon closer examination, some overlapping speech entails a harmonious coproduction of structure. In some speech communities listeners may contribute to the overall effectiveness of communication through a cooperative "conversational duet"; partners may encourage each other with overlapping speech (Falk 1979; Tannen 1979:100). By contrast, interruptions represent a breakdown of communicative cooperation. An interrupter cuts off the previous speaker, dismisses the old topic, and imposes a new one.

In relationships like that of patients to doctors, asymmetrical control of the topic (one conversational partner doing all the interrupting) reflects an asymmetry of power. Powerlessness

means loss of control. The interruptions relevant to the cases explored below are the “sudden and unilateral topic changes” that male physicians often make, particularly with female patients (Ainsworth-Vaughn 1992; Fisher and Groce 1990).⁶ Often, the effect is to limit patient responses to the minimum, even the monosyllabic “yes” or “no.” It is those patients who attempt to add detail to their minimal responses or who pursue psychosocial themes beyond the limited opportunity typically given to describe their problems (the “exposition exchange”) whom doctors are most likely to cut off. Many such patients are less likely to appear for follow up appointments, comply with instructions, or experience positive overall outcomes (Putnam and Stiles 1993). The quality of the practitioner-patient relationship or the extent of domination varies with the sex of the practitioner (Ainsworth-Vaughn 1992). Often, but not always, gender correlates with power. Males control topics and interrupt females more than females interrupt males (West and Zimmerman 1975, 1983); gender inequality exacerbates doctor-patient asymmetry when a female patient consults a male doctor. Medical relationships also vary across institutional sites such as private allopathic pharmacies versus Ayurvedic shops or even possession-mediums’ homes in Bangladesh and private clinics versus public hospitals in the United States (Lazarus 1988).

living in Matlab

I carried out fieldwork in Matlab, Bangladesh, between October 1991 and June 1992 to investigate complaint praxis. The staff of the International Centre for Diarrheal Disease Research, Bangladesh (ICDDR,B) helped me make initial contacts with medical practitioners in Matlab. The Matlab *upazila* (subdistrict) of Chandpur is approximately 50 kilometers southeast of Dhaka and reachable by river. It is home to 250,000 people and the site of field projects of the ICDDR,B in demography, epidemiology, and basic science that have led to hundreds of publications (Habte 1990). After settling in the practitioner-rich Sonargaon Bazar union of Matlab based on ICDDR,B surveys,⁷ I was able to focus on the patients of those practitioners and develop my own contacts with the sick and the healthy in their everyday life contexts.

Matlab is intersected by the Dhonagoda, a branch of the river Meghna. Annual flooding has ceased on the western side since the construction of an embankment.⁸ I lived and worked on the east side, where seasonal flooding still governs agricultural cycles. Like the overwhelming majority of their neighbors, the four patients live in extended virilocal family *bari* (homesteads or compounds) whose members cultivate rice, wheat, and lentils, harvest fruit from their shade trees, and collect greens to add to their curries. Within these patrilineal *bari*, families live and cook in separate dwellings but share a common courtyard. Some families in my study villages own a surplus of land with fish ponds and grow cash crops like potatoes and jute, with at least one educated household member who provides an income to the family through salaried employment. But landlessness is growing in Bangladesh, so that almost half the population subsists by selling their labor in others’ fields.⁹ Among those landless families is that of Fatima, the least confident of the four patients.

Matlab’s villages share much in common with other parts of northern South Asia. Village exogamy and virilocal residence help create a form of gender hierarchy—strict sexual segregation and exclusion of women from public domains—strongly contrasting with south Indian patterns. The Population Crisis Committee has ranked the status of women in Bangladesh as lowest in the world (1988). Female literacy then was 24 percent. One in five girls died before her fifth birthday, one woman in six did not survive her childbearing years, and female life expectancy was 49 years. Hanna Papanek has aphoristically described their status: “To Each Less Than She Needs, from Each More Than She Can Do” (1990).¹⁰

encounters with healers in Bangladesh

In early 1992 old friends in Dhaka told me a story about an adult male relative (L.). L. had loaned someone the equivalent of \$1,500—far more than the average annual income. I was not surprised to hear that the borrower failed to repay it. L. started visiting the debtor every day to ask for his money; even his sympathetic relatives called this “bothering [*birakta*] the debtor [D.]” According to my friends, D. consulted a kabirāj-sorcerer to drive L. mad and make him forget the debt. When L. did lose his mind, the family sought help through another kabirāj. My friends told me how this female kabirāj had divined the cause of L.’s problem without having any normal access to the story of the debt. And she cured him. “Had the debt been repaid?” I asked. They said, “No, L. ‘forgot’ about the debt—but at least he is well again.” Bangladeshis describing their visits to healers do not typically mention harmony among neighbors but, rather, the restoration of their loved ones as the desired end. Still, some cures do restore relationships. In the case at hand the result was as much to the liking of D. as to L.’s family. Had I pressed L.’s family, they might have expressed regret that the restoration did not include his money. In telling me L.’s story, however, they stressed the return of his sanity as a credit to the practitioner. Certainly their current satisfaction contrasts with L.’s pre-kabirāj focus on recovering his money.

I bring up this story and emphasize the multiple perspectives even within this patient’s family in order to introduce two questions. The first is that of the commensurability of the encounters I describe with those appearing in the medical sociolinguistics literature. It is possible to question the validity of considering both sets of encounters under one “medical” rubric. But the cross-cultural similarities are strong. Bangladeshis visit allopathic practitioners for largely the same reasons that people visit doctors in industrialized countries—perhaps to be tested and receive diagnoses but certainly to be cured of acute diseases or treated for injuries. Granted, Bangladeshis visit other practitioners—particularly homeopaths, herbalists, exorcists, diviners, and possession-mediums—for a wider variety of troubles, many of which they would never present to allopaths. Kabirāji medicine in Matlab encompasses almost all those varieties of practice. Sick or lost animals, rebellious children, marital problems, or dizziness and confusion might move one to seek out a kabirāj. Westerners in various eras have presented problems like those to curers, priests, psychiatrists, and family therapists. Once we grant that medicine has symbolic and pragmatic functions in the West and Bangladesh, the commensurability question loses urgency.

The second question is related to the first: Do Bangladeshi healers treat persons or groups? I raise the question because of Victor Turner’s (1964) influence and also because of the social dimensions of the above case and of those described below. In a Turnerian healing, returning patients to wholeness may be secondary or, at best, an entailment of the primary function of healing, that of restoring social groups to equilibrium. Applied to my data, this may mean one of two things: (1) satisfying the kin who arrange and pay for treatment, or (2) restoring the patient(s) to harmony with them (and, perhaps, the family to its status in the community). It seems to me that (2) is not as common as Turner might have hoped, which has important ramifications. “[I]n more complex social environments— . . . class-stratified societies, and so forth—there can be no . . . a priori assumptions of the therapeutic value, or even the existence, of such social and cultural coherence” (Steedly 1988:841); yet it is social coherence that, according to Turner, healing rituals create. In the cases I present, tensions between patients and others remain even while healing events attempt to reaffirm solidarity among the nonpatients.¹¹

An accepted truism of Indian sociology is that expectations of hierarchy pervade relationships in South Asia as much as egalitarian ideology pervades relationships in the West. Such expectations affect medical relationships. Even in Hindu India, however, subordinates expect to receive thoughtful and empathic consideration of even their unspoken needs in return for the honor they give superordinates (Roland 1988:220). Islam in Bangladesh and elsewhere

espouses an egalitarian ideology. Thus, while it is true that Bangladeshi patients might be willing to grant doctors more authority than a Western egalitarian ethos would countenance, literary and conversational discourse about practitioners' violations of the public trust manifest strong notions of reciprocity.¹² Moreover, concentration of medical knowledge has not reached high levels in the region; knowledge loosely reflecting the ancient Ayurvedic medical texts is still widely shared. Older women still practice noncommercial forms of healing in almost every compound in Matlab.

Practitioners—even diviners—typically refer to those who visit them as *rogī* (those who have a *rog* or “illness”). Practitioners differ, however, in their conceptualizations of, and pragmatic responses to, *rog*. In this pluralistic system clients choose the resort best suited to handle the problem as they conceive it. Regardless of the practitioner they finally see—if any—rural patients conventionally tend to link illness with the cosmos as ingested, offended, or otherwise experienced. Many foods have a humoral heating or cooling effect; ingesting them in excess or at the wrong time can upset the body's own balance. Spirits and living saints—like the lords of Bengal's semifeudal past and all the voices warning women to stay out of public view—are easily offended. Thus people may attribute symptoms of “madness” to an offended saint or spirit. Finally, diffuse symptoms may be attributed to ill winds and other *ālgā* (loose) things.

“If a baby does not cry, it won't get any milk.” This Bengali proverb recognizes the occasional need for self-assertion by complaining, although on the other hand superfluous complaining is criticized as *alaksmi* (inauspicious). Bengali has no inclusive category term for complaints about states such as illness or sadness. Everyday complaints about such states are referred to by the phrase *asubidhār kathā balā* (speaking about inconveniences). Marked or extreme forms of complaining such as ritualized texted *bilāp* (weeping) are salient enough to enter the lexicon on their own. Some styles of complaining make listeners uncomfortable, particularly those shading into nagging and begging. *Pyānpān* (*[pænpæn]* is the phonetic realization) refers to such repetitive whining. In his article on Bengali sound symbolism, Dimock (1989:60) notes that many iconic descriptors for “unpleasantness” contain the vowel [æ] and that its grating effect is heightened by nasalization.¹³ Though it is only those marked forms that are lexicalized (have their own words), everyday complaints are still recognizable. In addition to sharing semantic themes, everyday complaints typically use what Indo-Aryanists call the “dative subject” construction in which the first noun phrase in the sentence is, in semantic terms, the experiencer rather than the agent of the action (Klaiman 1981).¹⁴

Of course individual patients do not communicate in a vacuum but with interlocutors in diverse and stratified contexts. Interlocutors may elicit some complaints when they ask after others' health and yet criticize some of those very complaints. Animating such criticisms are folk notions of the language of humans and spirits as well as literary traditions that include sophisticated and explicit metadiscursive reflections. I take much of what people say about their own and others' speech as ideological. Ideologies refract practice. Thus folk discourse about complaints in Matlab or Los Angeles is at least one step removed from the speech of patients, let alone their putative aims in complaining. Contrary to what Fabrega claims for South Asian medicine in his discussion of the cultural specificity of notions surrounding somatization (1990:662), Bangladeshis *do* sometimes question the sincerity of particular complaints and the piety of troubles-tellers. Examples are documented by Hashemi and Schuler (1992) as well as in the present article.

A glimpse at the participant structure of women's visits to Matlab practitioners shows their complaints are mediated. At home with kin—to the extent that women's complaints do take verbal form—women speak for themselves. But when a woman visits a practitioner in his natural setting—which, as public space, is by definition not women's space—“guardians” must accompany and often *speak for* her. A postmenopausal mother—or, more typically, a husband, brother, or father—acts as “client” (Bhattacharyya 1986) or as the patient's “interpreter”

(Hasselkus 1992). Although guardians may have no greater communicative competence than women patients, they often serve as “interpreters” between the two parties, particularly “translating” practitioner’s questions into the intimate idiom of rural Bengali. By “intimate” forms I mean both the phonology and grammar that typify rural Matlab Bengali and thus signal solidarity, and also certain pronouns.¹⁵ Such a grammar indexes one extreme in solidarity or status/power-asymmetry. It contrasts with the grammar of distance- and face-preserving pronouns used by male practitioners in addressing patients and clients. This intimate language variety constructs a circle of solidarity that, by definition, encompasses kin and excludes distance-maintaining practitioners. It imports into the institutional setting a domestic form of interaction; asymmetrical use of intimate pronouns by “guardians” and the very act of interpreting for women reproduces their domestic status. Bengali women are constructed—partly through speech events like this—as dependent and as socially and physically weak. Yet, if they are aware of it at all, neither women nor men portray this process as a struggle; some women at least appear to invite “guardians” to speak for them. The benign face of protection perpetuates their disenfranchisement, the situation in which others speak for them; we must look in the cracks of discourse for signs of resistance.

I restrict the discussion now to transcripts of three women and one man who are referred to as *rogi* (patients). Two of the transcripts contain metacomplaints of the “I can’t tell” variety, one highlights a doctor’s evaluation of a complaint, and the last effectively illustrates the kind of conflict of interpretations that motivates metacomplaints. Such comments on the conversation at hand simultaneously index the social situation. The four interactions are heterogeneous in form and focus; problems and blockages vary with the lives in which they are embedded. Yet the “patients” all face one common obstacle to speaking their complaints freely: suppression, typically through interruption. In three of the four situations it is males who interrupt. Practitioners and kin typically interrupt patients, though sometimes patients also interrupt practitioners. In each event, participants contest the right to represent illness and its social context.

My recordings were made in a variety of circumstances. I sought out medical encounters in obvious places—the shops of pharmacists or *ḍaktārs* and sites where *kabirāj* healers see patients. Also, when people heard of my interest in illness, possession, and ethnomedical practice, they sometimes led me to unwell relatives or neighbors. On some occasions field assistants helped me conduct interviews, and we transcribed the tapes together. As to how representative the transcripts are of the lives of these four patients, my involvement with two was long-term—transcribed excerpts presented here are completely in character for them. As for the others, I must rely on data internal to the encounter and on other ethnographic knowledge including long-term relationships with all three practitioners. How should we locate the four transcribed interactions vis-à-vis the illness careers and social relationships that I make them represent? I make no strong claims about how the transcribed encounters affected illness careers, but I do describe the outcome of each case as I saw it.

transcripts and discussion

reading the transcripts The Bengali transliteration system I use is adapted from Bagchi (in press). Each of the following transcripts is arranged in two primary columns. The first (left) column contains the patient’s words as well as the words of those who speak for, or “duet” with, the patient (Falk 1979). The second (right) column contains the words of the patient’s interlocutors, particularly the practitioner. The columns thus become a means of representing roles played. That is, the transcript alignment distinguishes speakers who at least superficially speak on the patient’s behalf from those who are clearly not taking her role—including some who at

Table 1. Four encounters with practitioners.

Transcript	Patient	Patient description
1	Fatima	A middle-aged woman for whom an exorcist was called to treat transient losses of speech and consciousness.
2	Yasmin	A middle-aged woman with a painful lump above her breast.
3	Sufia	A young woman who sees a “doctor” for complications following a miscarriage.
4	Farhad	A young man complaining of diarrhea, dismissed by the “doctor” as mad.

other times did so. Some actors play alternating roles and are therefore placed in different columns according to the stance exhibited in the particular turn-at-talk.

Each transcript excerpt begins with a question-and-answer exchange that is conventional for ethnomedical encounters in Bangladesh. Problematic or uncertain hearings of a given word or words are indicated by setting those words in parentheses. Bracketed words in the English translation represent information understood by local participants but not easily attributable to specific morphemes in the Bengali text. Pauses in conversation are shown in seconds or tenths of seconds in brackets in the text. A colon (:) indicates nonphonemic lengthening for emphasis, and (=) indicates latching of utterances or the near overlap of two utterances. When two speakers overlap, overlapping speech segments are shown between slashes (/xxx/). Unrealized phonemes are written within parentheses in the middle of Bengali words (e.g., *ra(k)am*).

The form of the second person pronoun (or verb marking that agrees with it) varies in Bengali, something like *vous* and *tu* in French, with an additional third level. In the translations I have indicated these levels of respect marking as follows:

- V = Bengali *āpni* = deference-distance, like French *vous*
- T = Bengali *tumi* = equality-solidarity, like French *tu*
- sT = Bengali *tui* = extreme affection/intimacy or condescension/power asymmetry

Transcripts included here are excerpts of longer transcripts in the author’s possession. Omitted lines, noted in brackets, are not all part of the interaction in focus here and may involve bystanders or other nonfocal participants.

I turn now to present the four individuals’ encounters with practitioners (see Table 1).

Fatima, her sisters-in-law, and the exorcist Fatima is a woman with grown children, living—as does most everyone in Matlab—with her husband’s brothers and their wives in a compound of four households. Her daughters live with their husbands. She terms her 25-year-old son—on whom she would otherwise depend for her economic security—*sidha* (retarded, literally, “silly”). Although she is only about 45 years of age, the intense physical and emotional stress of her life in poverty shows on her thin, anxious face. During the interviews I had at her home, Fatima’s sisters-in-law usually spoke for her. They called her problem a *māthar byāram* (illness of the head) and indicated that her symptoms had a long history. Fatima had a frightened look about her. Her strength spent, she seemed to retreat before her more forceful affines.

It was shortly after I moved to Matlab in November 1991 that I first met Fatima. News of my interest in spirit illness and exorcism had spread quickly; specifically, it had reached Jahangir, whom Fatima’s family called in to perform an exorcism. At roughly 30 years, Jahangir is exceptionally young among local exorcists; others are at least 50. Jahangir makes his living

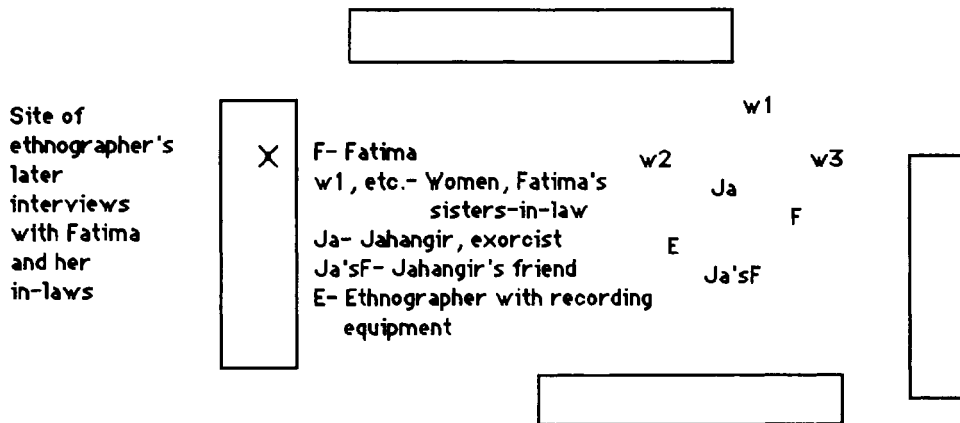


Figure 1. Fatima's compound: setting for an exorcism consultation.

selling cigarettes and betel leaves in Sonargaon bazar and tells me he performs exorcisms at no charge, in accord with a vow to his guru.¹⁶ Fatima and her kin confirm they gave Jahangir nothing, perhaps because the exorcism was aborted. Before that day I had met neither exorcist nor "patient," but—having heard of my interest—Jahangir and a friend came to meet me and invite me along to Fatima's compound. When we arrived there I received permission to record the whole consultation. After the initial awkwardness during the setting up of the microphones the consultation moved smoothly. When Jahangir concluded that Fatima's condition was not caused by a spirit the consultation came to an end and we left. I revisited Fatima's compound twice over the next year to ask about the encounter. In those interviews I tried to understand the family's experience of the consultation with Jahangir. My male and female field assistants decided how we would ask the women about their impressions of his style, his questions and conclusions. On no occasion did anyone interview Fatima *alone*; the idea of a private consultation between a local woman and any party including unrelated men is almost unthinkable in Matlab.

Jahangir was quite sure of his conclusion, and on the path home he listed some of the deviant behavior patterns he expected in cases of possession but had not seen that day. It was only when I visited without Jahangir that Fatima and her sisters-in-law described those of her symptoms over the last several years that had prompted them to seek treatment for a spirit illness. On those later occasions I found the women at leisure; both interviews lasted an hour. Jahangir had left after 15 minutes, perhaps because he relies on income from his shop and no one was minding it for him that day. Perhaps, in his inexperience, he was unaware of the varieties of spirit illness as distinct from possession. Given the likelihood that Fatima's family would have felt obliged to offer Jahangir something for an exorcism, I credit Jahangir's integrity for declaring that his services were not needed. Some of the women in Fatima's compound had enough experience to know that expatriates might *give* gifts and require none in return. More than any fault of Jahangir's, these factors probably explain why the women gave me information they had not given him.

Rain forced us indoors for my ethnographic interviews, but during the abortive exorcism all participants sat in the pleasant November sun in the courtyard shared by the four thatch dwellings of the compound (see Figure 1). In a conventional display of hospitality, the women provided the bari's only three chairs for us while they themselves sat on the ground. I listened while Jahangir tried to gain all the information he needed from Fatima herself. Fatima's sisters-in-law repeatedly "helped" or mediated in the interview. Jahangir resisted this characteristic of Bengali folk-medical interviews, perhaps because he could read the discomfort on

my face each time the sisters-in-law would interrupt or berate Fatima. Or he might have considered a recorded event (see line 18 below for his awareness) too formal for interruptions.

Key to Fatima's transcript.	
Denotation	Speaker's name and/or identity
F	Fatima, the "patient"
J	Jahangir, the exorcist
W	One of several sisters-in-law coresident in Fatima's compound and participating in the interview

Transcript 1

- 1 J: *āpnār ki abasthā lāglo?*
How did your [V] situation begin?
- 2 F: *ki ra(k)am lāge . . .*
What it felt like . . .
- 3 *sārindā sallā kaipā jāman āy sallā ekkābāre ki ra(k)am je lāge . . .*
The whole body [was] trembling like—my body completely—it felt like . . .
- 4 *kono ār kaite (p)āri nā.*
I can't tell you any more.
- 5 *kaite (p)āri nā ki ra(k)am je lāge.*
I can't tell how it felt.
- 6 *(ey janlāṭā fikkā . . . or ey jāni nā fikkā . . .)*
(I don't know . . .)
- 7 */ājñān haiyā jāi./*
/I go unconscious./
- 8 W: */ājñān haiyā./*
/[She's been] going unconscious./

After line 8 Jahangir asks about Fatima's history of treatment, once rebuking the sisters-in-law for their uninvited reminders of treatment details. Then he returns to Fatima's present state. She points to her head and says the house spins, and something tries to "push her down." Perhaps hearing this as the basis of the family's attribution of Fatima's symptoms to a spirit, Jahangir asks directly about that in line 9:

- [22 lines omitted]
- 9 J: *ācchā tā haile ālgār kichu āsari mane karen*
apnārā nā ki?
Hmmm, so then do you all think that something
"loose" is influencing [her]?
- 10 W: *āche.*
There is.
- 11 J: *ālgār kono ās/ari/*
There's something loose /influencing/
- 12 F: */ālgā/ tanai nā sarir durbal tani eyṭā kaitām pāri /nā/*
/[Whether my symptoms are] from a "loose thing"/ or
from bodily weakness, that I could not say.
- 13 J: */ācchā./*
/Hmmm./
- 14 F: *nā āy tāypār jbarār /mathā . . ./*
Or that type of fever (in the) /head . . ./
- 15 W: */her thar/ kiser thar kane kaya.*
/What garbage!/ What a bunch of garbage
she's telling!
- 16 *jetā kas kāme kas.*
What you [sT] say make it useful!
- 17 *eyṭā to kāme lāgbo nā.*
This isn't useful.
- 18 J: *[to Fatima's sister's in law] apnārā keo kichu*
balen nā ekhāne emne rikardiñ haite ache. [.5]
Don't say anything any of you [V]: right now
recording is going on. [.5]

19		ha tārpar giyā tā ekhan to āpni sustha. Yes after that . . . [so] now you [V] are well.
20	F: ha. Yes.	
21	ey sandhār pare eman lāge— After sundown it feels like—	
22	erakam lāge. It feels like “this.”	
23	durbal sarire /er thekeo akhāne . . ./ weak in the body /now more than . . ./	
24		J: /tā haile/ to e sabe ālgār kichu nā āmār mane haya. /So then/ this all has nothing to do with spirits, it seems to me. hāito durbaler theke emne lāge. Maybe it’s from weakness that [you] feel this way. [9 lines omitted]
25		ha, tā haile ai tā haile āpner bhālo bhālo jinis khāite haibo . . . Yeah, so then you [V] have to eat really good things . . .
26		

In the cacophony that typifies a multiparty conversation, Fatima tries to present a coherent view of her mysterious symptoms. Her most nonspecific and flagging attempts to express herself are seen in lines 4, 5, and 22. Fatima’s sisters-in-law sometimes supportively “duet” her speech as in lines 7–8; but they interrupt her with ridicule in lines 15–17.¹⁷ In that sense we cannot hold Fatima solely responsible for “not being able to speak,” nor can we map subjection-domination directly onto “female and male” or patient and practitioner. Fatima’s metacomment in line 4 (“I can’t tell you any more”) can be taken as an indirect protest to the female members of her husband’s compound. Jahangir usually presents himself as concerned only with Fatima’s version, resisting the attempts of the other women to play a role in the interview he is conducting; thus his elicitation of their opinion in line 9 comes as some surprise. At several points like line 19, however, Jahangir invites Fatima to continue her story. She begins to speak fluently, but—as though she were struggling to create a new language for her body’s distress (Scarry 1985)—bogs down in the attempt. She tries to say something about her “whole body” in line 3. Beyond the verb “trembling,” however, she is at a loss to specify much about her state, letting line 3 dangle with the indirect question “How I feel . . .” In line 7, she offers unconsciousness as the reason she “can’t say,” as if her inability to describe her experience somehow needed to be justified.

When Fatima repeats the theme “I couldn’t say” in line 12, she indicates that she is unable to decide which of two diagnoses fits her better. A contingent diagnosis of spirit illness brought the exorcist to the scene, but now she proposes another—*durbalata*.¹⁸ Although this sort of “weakness” in Matlab may refer to social vulnerability or inadvisable emotional transparency, Fatima offers it—and Jahangir accepts it—as a materialist alternative to the hypothesis of *ālgār āsar* (influence by something loose or wild). It has the advantage of limiting the problem to a tangible domain (i.e., nutrition) but the disadvantage of calling for a long-term increase in consumption beyond Fatima’s means (line 26). Jahangir’s nutritional advice fails to come to grips with her family’s economic status. Her husband sells his labor by the day and her son cannot help her. Stratification within the compound renders Fatima’s status marginal. Her sisters-in-law seemed vigorous and assertive beside her. Even if we accept a portrayal of the whole compound as an impoverished environment that compromises health, it is always the case within such environments that “some are for social, psychological, and biological reasons at enhanced risk” (Kleinman 1986:182).

The other hypothetical diagnosis, “loose/wild influence,” captures the mysteriousness of Fatima’s incompletely described experience. In the local schema the “influence” diagnosis calls for exorcism, which might have seemed more within Fatima’s reach than long-term nutritional change. In line 12, however, she displayed ambivalence toward talk of “loose” things; reasons

for this emerged in follow-up interviews. Among the symptoms that Jahangir failed to elicit were episodes of speechlessness lasting for days at a time. It is the story of this symptom that helps us understand why Fatima was disappointed when the exorcist left her with the diagnosis of weakness and the suggestion that she eat better. Her ambivalence towards the two diagnoses reflected her feelings towards the moral implications of *alga* and the economic implications of anemia.

“Moral implications” do not only include the fact that spirits attack women who violate *pardā* (norms of gender segregation or female seclusion). The exorcism consultation itself brought to mind what Fatima associated with the world of spirits—a very particular “transgression” and lost opportunity. She and her family regard her speechlessness—and perhaps her dizziness and other somatic symptoms—as the result of violating a taboo. At least a year before Jahangir’s visit, a mysterious *alim* (male Muslim cleric) appeared privately to Fatima, and only to her, forbidding any revelation of his presence. Her violation of this injunction caused her muteness. Her speaking of him, it would seem, transformed the ghost-*alim* into a *bobā*. In unmarked usage *bobā* refers to persons whose hearing and speech impairment has natural causes. The marked usage describes a speech-blocking spirit that typically visits at night; this sort of *bobā* presses on the victim’s chest, literally choking off speech but sparing the hearing. (One might compare this Bangladeshi experience with reports of night terrors from other parts of the world [Hufford 1982].)¹⁹ Thus Fatima’s experience of being mysteriously silenced is not isolated. She was one of three persons who described for me their experiences with *bobā* spirits. All three victims took spiritual measures aimed at delivering themselves of the unwanted visitations, but—for Fatima, who lost speech for a number of days at a time, and the other man, who had almost nightly episodes—the *bobā* problem proved refractory. Fatima was no longer experiencing mutism when I met her; but her family considered her physical symptoms to be part of the still unresolved spirit-sickness.

Of the transcripts presented here, Fatima’s contains the most complex metacommunication. The life history she conrarrates with her sisters-in-law is peppered with demurrals of the “can’t say” variety.²⁰ *Kawā* (speaking—or not speaking) appears at three levels in that story. First, the *alim* forbade her to speak of him. Then, when she told her secret, her experience of him/it was transformed. Finally, as *bobā*, his influence upon her prevented her from speaking at all. This can be construed as the revenge of the *alim*. The *alim-bobā* can also be interpreted as the idiom in which Fatima indicates the gender of the power that silences her again and again. Once burned, she is twice cautious about speech. For Fatima, speaking—particularly in reference to her own condition and its ambiguous relationship to the realm of the mysterious—has become problematic. Her own self-reports to the exorcist and ethnographer are as weak as her own words indicate: “I can’t say . . .” Fatima’s situation and her condition are basically unchanged; her speech does little more than confirm her weak position in her social world.

Yasmin, her brother, and the herbalist Ali In the same month I met Fatima, ICDDR,B staff had suggested that I observe the practice of herbalist-kabirāj Ali. The first of three times I met Ali was the day Yasmin sought treatment from him. Ali’s practice—relying on the pulse for diagnosis, conceiving of disease causation in humoral terms, and countering humorally “hot” and “cold” imbalances with dietary interventions—reflects Ayurvedic influence. But his contemporary environment is competitive, dominated by cosmopolitan biomedicine. Thus much of his therapeutic banter with patients like Yasmin aims to assure them—and visitors like me—that his medicine works. In an interview with me Ali swore that his patent remedies—herbal preparations in a molasses base rolled into brown balls 1–2 centimeters in diameter—are the only cures in the world for cancer, gangrene, and *bārzin* (an apparently idiosyncratic diagnostic category).

By the time 50-year-old Yasmin showed Ali the lump near her clavicle in November 1991, she had suffered for at least nine months. It seems she had fallen from about seven feet while reaching for something in the “attic” found in all the beam-and-tin or thatch dwellings of Matlab. During their consultation, Ali asked Yasmin about the many other practitioners she had seen. She had visited Dr. Nazar—the one female doctor in the area—an M.B.B.S. serving at the public hospital in Chandpur, the district seat of government. Yasmin quoted various diagnoses in English and Bengali. She said that after x-rays, and presumably other tests, Dr. Nazar had called the lump—confusingly near her fracture—a *kænsār tyumār* (cancerous tumor). One doctor found ulcers, another tuberculosis. Now Yasmin sat in Ali’s little shop. She complained of pain radiating from the clavicle through one whole side of her body and also of insomnia and a complete loss of appetite. But such a summary fails—as did Ali’s feedback—to capture the force and life-meaning of each “symptom-exposition” (Putnam and Stiles 1993) and the difficulty of the dialogue through which each symptom emerged.

In their consultation in November 1991, Ali first asks Yasmin to tell him the problem. As if she hasn’t understood his question, her brother “translates” it, urging her with intimate/condescending pronouns to narrate the problem. She has begun to describe her pains in detail when her brother adds specifics on the *usila* (the “how” or origin) of the problem. Yet when Ali asks about her pain (line 3), who but Yasmin can put it into words (Scarry 1985)?

Key to Yasmin’s transcript.	
Denotation	Speaker’s name and/or identity
Y	Yasmin, Ali’s “patient”
A	Ali, practitioner of Ayurvedic herbalism
B	Yasmin’s brother and “guardian”

Transcript 2

[64 lines omitted]

1 Y: *rāyt /kairā—/
/At night—/*

2

B: */ey fulā diche/ aditā bhāynā gæche, bhāynā gæche.
/This swelled up:/ the bone’s broken, it’s broken.*

3

A: *acchā, eytār bhitāre byāthābedanā ache kichu?
Hmm, is there any pain inside this place?*

4 Y: *ha rātdin!*

Yeah—night and day!

5

ghum jāite pari nā, ekhano kai ni to, ardhek kathā kai ni.

I can’t get to sleep—I haven’t yet told you. I haven’t told the half of it yet.

After line 5, in the 22 lines of speech omitted from the transcript, Yasmin distinguishes several aspects of her pain and explains why it keeps her from sleeping. She summarizes her desperate state where the transcript resumes in lines 6–9, to which Ali’s response (line 10) seems to be an anxious return to procedures that comfort him rather than his patient.

6 Y: *ay mātḥāo laiya sinsine bāgechāge laiye jāya.*

The tingling pain in that²¹ head splits it in half.

7

ekhan ār śānti nāy kono rakami.

There is no longer any sort of relief [or “peace”].

8

[someone coughs]

9 Y:

eṭār laigāo śānti nāy hetār laigā śānti /nāy./

There is no relief from this, no relief from /this./

10

A: */to/ āpner jibātā ektu dekhān āmāre. [5]*

/So/ please show me your tongue. [5]

In the 11 lines omitted after line 10, the two discuss Yasmin’s problems with digestion and elimination. Just as she concluded her turn in lines 6–9 with a general statement of her despair,

so line 15 below gives Yasmin’s interpretation of the seriousness of her trouble with food, expressed in lines 11–14.

- 11 A: *acchā khāwā dawāy āpnār asubidhā kare ki?*
Hmm, does eating cause you [V] trouble?
- 12 Y: *asubidhā ache nā? buk tirāṣ lāge nā?*
Isn't there trouble? Isn't my chest/throat dry?
- 13 *āndājer upare jāni dugā dugā diyā thellā bahe theyllā.*
By guessing [how much I can tolerate] I force down little bites.
- 14 *bhar kairā theyllā theyllā khāwā (theke barabala).*
I shove it (right) down [my own throat].
- 15 *amar to jiban-o muchon²² ārambho /hailo./*
My life is beginning to be /erased./
- 16 A: */khidā tiṣnā/ kam?*
/Weak appetite/ and thirst?
- 17 Y: *khidā ek(ēb)āre nāy.*
I have no appetite at all.

Yasmin herself eloquently characterizes her struggle to tell the whole story: “I haven’t told the half of it yet!” (line 5). She has had intermittent opportunities to speak in the three minutes before this excerpt, but line 5 reflects Yasmin’s anxiety that she might not finish her story. It exemplifies the balance of indirection and assertiveness that is Yasmin’s adaptation to her conversational environment. It is a metacomment that leaves unstated the reason for which she has not been able to tell half of it: her interlocutors will not let her. For them to take a turn at talk while she is pausing is one thing. But—before and after line 5—Yasmin’s brother and the herbalist interrupt her as she is responding to a question, listing things, and beginning an important theme.

Their most striking interruption follows her disturbing and perceptive remark in 15, “my life has begun to be erased.” To be fair, Ali’s line 16 is a tentative summary of Yasmin’s words, and in 17 she confirms he has the gist. But his summary (“no appetite?”) misses Yasmin’s affective tone and trivializes her life-and-death struggle. It is true that concern over appetite loss is widespread in the household context as well as that of folk medicine (Nichter 1981:382). It is also true that practitioners and other listeners expressed to me in interviews the belief that they have an obligation not to empathize with but to fight feelings of despair. Thus two situated notions of therapeutic speech clash here. The patient is keen to express a fear that she may be dying while the healer believes he must ward off all signs of despair. Yasmin’s brother’s willingness to spend time and money for her must be recognized. And the motivation of practitioner and kin for suppressing Yasmin’s words, if at all conscious, is benign. But there is no doubt that, at an unconscious level, Yasmin’s eloquent representation of her inner world threatens the world crafted by men such as her brother and the herbalist. They cut off the rhetorical line she is pursuing before the threat can take mature form.

The recorded encounter between Yasmin and Ali was the first and last time I saw her. Despite my January foot search through the vicinity where she reported living and later searches through ICDDR,B’s demographic records—the records that had motivated me to choose Matlab as a field site—I failed to find her. Only in April 1992 did I find her “address” and her records—with the latest entry in ICDDR,B’s archives reflecting her death in March. My linguistic consultants regard the clarity, volume, and sheer persistence of Yasmin’s speech as remarkably assertive for a Bengali woman. Probably it was her persistence that had persuaded her brother to spend a little more money seeing Ali that day rather than give up after hearing the grim diagnosis of several other practitioners. Perhaps that persistence extended her life a little even while social and medical constraints—mediated by verbal interaction—conspired against it.

Sufia’s visit to Heykal As with Ali and Jahangir, it was also early in my fieldwork that I met Heykal. But Heykal’s shop was on the path I walked almost daily so I had much more contact with him throughout my stay in Matlab than with the others. Beyond observing and recording

a number of his clinical interviews, such as that with Sufia, I enjoyed many cups of tea with the *ḍaktār*.

Heykal is a *hātuli (hāturiyā) ḍaktār*, a “doctor” who becomes so by doing: picking up a figurative hammer (*hāturi*) and using it.²³ Kabirāj like Ali and most *hāturi ḍaktār*s practice in pharmacies that they own and run.²⁴ But whereas Ali prepares his own remedies, Heykal’s medicines are almost all manufactured by multinational pharmaceutical companies in Bangladesh, spanning the range of items available in the West. More than other Muslim practitioners in Sonargaon bazar, Heykal displays his piety openly in his clothing and speech. Patients, however, do not bring him problems like mutism or forms of deviance that they regard as spirit-caused and thus within the domain of the *kabirāj*. As a *ḍaktār*, Heykal’s orientation is toward cosmopolitan/allopathic medicine; he accepts a scientific way of knowing. Relative to *kabirāj* he gives patients less time to answer open-ended questions. He is friendly but business-like. We can compare his style with that of practitioners of biomedicine in other societies; he is a “nice doctor” (Davis 1993) who interrupts but is also interrupted and who *sometimes* pursues patients’ themes in his questions (Mishler 1984). As in Mishler’s depiction of doctor-patient interaction in America, however, Heykal’s agenda of questions takes on such a life of its own that the patient’s and family’s concerns get lost. In a very subtle way, moreover, Heykal’s response to Sufia’s symptom-account challenges her authorial power to describe her own experience.

Sufia and her family walked about three miles to see Heykal in January 1992. They told Heykal of her lower abdominal pain and pointed to a lump, perhaps in Sufia’s uterus. She and her mother conarrated the history, linking the lump with the aftermath of a miscarriage. With male and female field assistants I visited Sufia’s home two months after she saw Heykal. We played portions of the audiorecording of that consultation and asked about her current state and the history of the problem as well as how she and her mother had felt about the interview. Like Heykal, we could not avoid the mediation of her parents; unlike the *ḍaktār*, we could not fulfill their expectation that we would also provide medical help. Sufia’s family told us that her husband had sent her back to her parents after the miscarriage and her later failure to achieve a successful pregnancy and birth.²⁵ They also linked the mysterious lump with spirits. Neither issue arose in their consultation with Heykal. After that visit to her parental home I saw Sufia on one other occasion—in Sonargaon bazar, evidently shopping, probably with a “guardian” nearby. The consultation transcribed below opened with Sufia’s mother and Heykal urging her to recite her medical history. But Sufia’s attempts to tell her own story fail, and her mother takes up the task in line 5.

Key to Sufia’s transcript.	
Denotation	Speaker’s name and/or identity
S	Sufia, Heykal’s “patient”
H	Heykal <i>Ḍaktār</i> , allopathic practitioner
M	Sufia’s mother and “guardian”

Transcript 3

- | | |
|--|--|
| 1 | H: ey ki asubidhā āpnar?
What is your [V] problem here? |
| 2 M: kabi nā?
Won’t you [sT] speak? | |
| 3 | H: ki asubidhā balun.
Tell [V] what’s the problem. |
| 4 S: prathamā?
The start? | |
| 5 M: lāge (nān) cakār matan ār ki. [2] | |

- 6 *It feels like a (?) mass or something. [2]*
 ay je e apnāder sāthe nā jato owsudbari nilām nā?²⁶
 Remember how many pills we got from you all?
- 7 ey māyār leggāyi niyechilām. e bāccā (huynā) chilo.
 It was for this girl we got them. She was (?) pregnant.
- 8 tārpār ey bāccā— [1]
 Then the fetus— [1]
- 9 mane karen dilibhāri dekhā geche.
 imagine delivery [miscarriage] started.
- 10 tārpār eṭā āsteyi eytā—
 Then gradually it—
- 11 H: sairā geche. kakhān se saireche?=
 fell away [miscarried]. When did it fall away?=
 12 M =eytār cākātā raiyeche pare.²⁷
 =This mass stayed behind afterward.
- 13 H: kā māser bāccā nāstā haiyā gelogā?
 A fetus of how many months was spoiled?
- 14 M: chay māse.
 Six months.
- 15 S: cā:r māser. cāyṛ māser.
 Four months. Four months.
- 16 M: cā:r māser.
 Four months.
- 17 H: cār māse nāsto haiyā gechegā /eṭā ki?/
 It got spoiled at four months; /what is that?/
 18 S: /cā:r/ māś cār māś bhālo chilo.
 /Four/ months . . . for four months it was fine.
- 19 H: ki?
 What?
- 20 S: cār māś par
 After four months
- 21 /thekey er pare/
 /from that point on/
- 22 M: /ekṭā rog hailo./
 /an illness started./
- 23 S: ekṭā rog haiyā—
 The illness which started—
- 24 H: ki /hailo?/
 What [kind] /started?/
 25 S: /ek/ der māś ekṭā peṭ byāthā.
 /There/ was abdominal pain for one-and-a-half months.
- 26 H: ācchā; tārpār?
 Uh huh; then?
- 27 S: eytār theke ek der māś rakta geche.
 From this, bleeding lasted one to one-and-a-half months.
- 28 rakta jāwār par peṭete cākār māta iyā geche.
 After the bleeding, something like a mass formed in the abdomen.
- 29 erpar (ekh)ane māś māś jāite āche.
 After that, now the blood passes monthly.
- 30 [2] /ekhan./
 [2] /Now./
- 31 H: /ekhan ki/ jāite āche?
 /Now is/ [blood] passing?
- 32 ekhan rakta (kono beśi) geche?
 Now is there (irregular) bleeding?
- 33 S: nā ekhan māś māś jāya.
 No, now it passes monthly.
- 34 H: ekhan māś māś jāya?
 Now it passes monthly?
- 35 māś māś balte oṭā thik āche.
 Because it's monthly things are OK.
- 36 eto /(saktā) problem nāy./
 It's /not that hard a problem./
- 37 S: /āmār pēter madhye cākār matani./
 /There is like a mass in my abdomen./
- 38 (se) āger cākār matan cākā.
 (That) old mass-like lump.

- 39 H: *ager mata, cākā haiyā geche, nā?*
Like before, mass has formed, huh?
- 40 S: ha.
Yeah.
- 41 H: [inaudible]
- 42 S: *sey āgertāi.*
It is the old mass.
- 43 H: *bujhechi.*
I understood.

Between line 43 and line 44 Heykal asks Sufia more questions about how well her menstrual blood flows, whether it “breaks up” normally. She says it does. He then asks her about the mass.

- [13 lines omitted]
- 44 H: *ekhan ki pete cākā anubhab karte āchen?*
Do you [V] sense a mass in your abdomen now?
- 45 S: *Mhm, pete cākā āche.*
Yes, there is a mass in [the] abdomen.
- 46 H: *cākā anubhab kartā /chen./*
You [V] /are sensing a mass./
- 47 S: */ha./*
/Yeah./

I find two points of conflict in Sufia’s encounter with Heykal: first over her pregnancy, then over the lump. In the opening lines of the transcript Sufia defers to her mother’s recounting of events. Heykal pursues the chronology with Sufia’s mother, focusing on the miscarriage. Sufia’s mother avoids the blunt Bengali verb phrases that Heykal (perhaps insensitively) supplies, finishing her sentence with *saireche* (“fell away,” line 11) and *naṣṭa haiyā gelogā* (“got spoiled,” line 17). In lines 14–15 Sufia corrects her mother’s mistake (“it happened at four, not six gestational months”); at this point Sufia finds her voice and her mother’s role recedes to the background. Heykal’s use of *naṣṭa* (spoiled) was like a red flag to Sufia. Evidently unwilling to let the man thus dismiss her reproductive career—her marriage and economic security depended upon successful performance here—Sufia herself steps in to construct the event more positively, emphasizing that for four months the pregnancy had progressed well.

Both women emphasize the *cākā* (mass, lump) in Sufia’s lower abdomen (lines 5 and 28). At first Heykal ignores them. There are marks of intensity when Sufia tries to return Heykal’s attention to the lump in line 37. The grammatically unnecessary personal pronoun *my* and the fact that she was interrupting the practitioner’s questioning agenda (Mishler 1984) make the utterance noticeably assertive. Heykal’s first acknowledgment of the lump in line 39 is a wooden echo. The tension between them reaches a climax in lines 44 through 47 when Heykal rephrases Sufia’s statement with the verb-phrase of perception *anubhab kar* (sensing, subjectively feeling), thus devaluing her account. Although Heykal utters even these lines in a friendly or sympathetic tone, we cannot fail—any more than did Sufia—to miss his repetition of that verb phrase in lines 44 and 46. Nor can we overlook Sufia’s assertive response in 45 in which she insistently substitutes *āche* (the existential/assertorial verb “there is”) for *anubhab kar*. To paraphrase her, Sufia says, “It’s not, as you say, a subjective experience; there is a mass in my abdomen.” As in the conflict over her pregnancy, Sufia resists the “voice of medicine” (Mishler 1984). Like Heykal’s performance, however, hers is less confrontational in volume and voice quality than at the lexical-grammatical level; the conflict thus remains below the surface. Finally, deferring to Sufia and to the family’s collective insistence that he take the lump seriously, Heykal performs an external abdominal examination.²⁸

At both points of conflict Sufia asserts her competence: her power to nourish a fetus—if only for four months—and to verbalize the state of her own reproductive organs (“there is a lump”). But such self-assertion is radically constrained. In my home interview no member of Sufia’s family blamed her husband for sending her away—or Heykal for dragging his feet before doing the examination. As for Heykal—despite his gentle manner and his economic interest in treating

the problems Sufia presents—his words reproduce the local and bioscientific delegitimation of women’s voices. As the next case shows, this tendency to question patients’ narrative authority extends beyond cases like Sufia’s.

Heykal dismisses Farhad’s complaint By manipulating words and selective attentions, a Matlab practitioner may determine who among those who visit him becomes a speaking subject and who remains the object of his gaze, discourse, or derision. Because of the inherent asymmetry in the practitioner-patient relationship, such authority to construct persons can never belong to the patient. In that sense labeling is the exclusive privilege of the practitioner. Forms of this privilege vary across practices and institutional sites in Matlab—a dialogical reality may underlie the appearance of a practitioner’s diagnostic privilege in exorcism, divination, or even Ali’s herbalism—but the match between interview practice and the ideology of practitioner privilege is close in Heykal’s interaction with Farhad. In this encounter two practitioners objectify their patient (more than his illness) in a particularly unilateral way.

Farhad is a 30-year-old man; the only time I saw him was during the course of events transcribed here. What I say about that event derives from my knowledge of Heykal and from their interaction as I recorded it. Heykal evidently knew Farhad; he acted as if Farhad were so insane that no one was under any obligation to attend to what he said. I have no way of assessing that claim, but it clearly placed Farhad beyond the possibility of receiving medical attention for his complaints. As a paramedical clinician and using antipsychotic medications, Heykal is capable of treating acute mental illness. Interestingly, he has told me he provides antipsychotic injections to other patients, but under the supervision of a psychiatrist. Perhaps Heykal reacted to Farhad as he did because, since his training is minimal and pharmacologically oriented, his ability to treat psychiatric patients is limited to a dispensing role. Heykal’s behavior toward the young man—chuckling and making clearly audible remarks about him to others—was no better and no worse than the common treatment of the publicly “mad” I observed on many occasions in Matlab.

Heykal was busy in his inner chamber when Farhad first appeared. Other patients and pedestrians were also present when Heykal’s apprentice invited Farhad to speak.

Key to Farhad’s transcript.	
Denotation	Speaker’s name and/or identity
F	Farhad, Heykal’s “patient”
A	Alfrentis, Heykal’s apprentice
H	Heykal Daktar
X	Unidentified speaker (not one of the above)

Transcript 4

- | | | |
|---|--|--|
| 1 | | X: ki haiyeche kaiben to.
<i>Tell [V] what happened.</i> |
| 2 | F: pettā biş kare ar ki.
<i>The stomach hurts or something.</i> | |
| 3 | | A: ha.
<i>Yeah.</i> |
| 4 | F: ar pâykhânâr sâthe ektu hâw o jāya.
<i>And a little mucus passes with [my] stools.</i> | |
| 5 | | A: hâw o jāya?
<i>Mucus passes too?</i> |
| 6 | F: sinsine bedanā kare (e raham).
<i>[It] tingles and hurts (like this).</i> | |
| 7 | | A: amāşā haiyeche?
<i>Has there been diarrhea?²⁹</i> |

8 F: ki jāni?
What do I know?

The transcript opens with the apprentice's smirking invitation for Farhad to present his symptoms. Farhad took the opportunity and presented his complaint (lines 2 and 4–6). In mock seriousness the apprentice echoed Farhad's words (lines 4–5) and then (line 7) asked if he had *āmāšā* (a form of dysentery). Assuming that the term always indicates bloody stools, the practitioner could rightly expect the patient to know if he had *āmāšā*. But Farhad replied *ki jāni?* ("What do I know?"). Perhaps he simply had not noticed blood; at the very least, his words represented an admission of ignorance in the face of medical authority. They may also have represented an indirect request for the kind of dialogical scaffolding—the practitioner's reminding him what signs distinguish *āmāšā* from other enteric conditions—that would make it possible to confirm the diagnosis. Perhaps since *āmāšā* is considered more serious than other types of diarrhea, Farhad felt that to confirm this diagnosis was not his job but that of the *ḍāktār*. Finally, the words may have betrayed Farhad's awareness that his listeners are scarcely hiding their scorn for him.

When Heykal emerged from his inner chamber (some minutes after line 8) he noticed Farhad waiting but did not speak to him. Like the apprentice the *ḍāktār* chuckled at his patient. I still expected Heykal to begin a medical interview. Instead, he turned to me and made gestures indicating that Farhad was mentally ill.

[42 lines omitted]

9

H: brenles to!
Really brainless!
ar kathā [.8] kathāi bhelyules.
His talk [.8] his whole talk is valueless.

10

For Heykal not only to ignore but belittle his expectant patient left me feeling very uncomfortable. At the same time, the *ḍāktār*'s behavior bears a distant affinity to one model of medicine. This response to Farhad evinces a belief that complaints do not always mean what they say and that the manifest content of the speech of the "brainless" or "mad" can or should be ignored. The sources of his concept of mental illness are not clear. Given that his formal schooling is minimal, I suspect that Heykal draws in part on ethnopsychiatric folk knowledge. But there is also a fascinating parallel between his praxis and that of psychiatrists in industrialized countries treating vague or "excessive" symptom expression as a sign of "somatization disorder." Heykal assumes the right to question his patient's attribution of distress to a bodily symptom. Unlike his Western counterparts in biomedicine, however, Heykal does not pursue the somatization diagnosis further by prescribing any psychopharmaceuticals—despite the fact that he sells them to other patients. He simply waits for Farhad to leave. Farhad, in contrast to Sufia, offers little resistance to Heykal's dismissal. He smiled, as people in rural Bangladesh do when shamed.

My point has nothing to do with my friend Heykal personally. Rather, I offer the commonalities of his interaction with Sufia and Farhad—delegitimizing their presentations of self and symptom—as evidence for general tendencies. I write of the tendency for patients to clash with practitioners or kin over their self-representations as well as over explanatory models for their current state, and for some to resist the authority of the practitioner. My point is that medical discourse is at least indirectly about conflict as well as illness and treatment.

conclusion

A tabular presentation facilitates our grasp of the common patterns shared by the interaction of Fatima, Yasmin, Sufia, and Farhad with their practitioners (see Table 2).

In this article I have represented events in the lives of four rogī in Matlab, stressing conflictual aspects of their medical interactions. It is not the case that all overlap in medical conversation

Table 2. Summary and comparison by patient pseudonym.

	Fatima	Yasmin	Sufia	Farhad
1. Sex and approximate age	Female, 45	Female, 50	Female, 20	Male, 30
2. Event setting	Home	Chambers	Chambers	Chambers
3. Complaint theme	Dizziness, fainting	Tumor	Abdominal mass/lump	Diarrhea
4. Metacommunication	Patient: "I can't say how it feels"	Patient: "I haven't told you half . . ."	Practitioner: Reinterpretive paraphrasing	Practitioner: "His . . . whole talk is valueless"
5. Forms of blockage/inhibition	Confusion, interruption, ridicule	Interruption	Struggle for discursive epistemological authority	Ridicule
6. Practitioner	Exorcist-kabirāj	Herbalist/Ayurvedic kabirāj	Biomedical dāktār	Biomedical dāktār
7. Relationship with practitioner	Unhelpful	Frustrating	Conflictual unsatisfying	Ridicule
8. Supernatural agency invoked	Male spirit silencing her		Spirit as cause of her lump—not mentioned to practitioner	
9. Social label	māthā-byārāmī (one with a head illness)	rogī	rogī	"brainless"
10. Outcome	Inconclusive, conflicting diagnoses	Died six months later	No improvement	No improvement

entails interruption of the patient or that sympathy is never offered to Matlab patients, any more than it is true that Western practitioners universally ignore or delegitimize their patients' words. But even in situations in which patients are allowed to present relatively long illness narratives, practitioners and kin in Matlab disrupt those narratives. Within the context of certain relationships it is not unusual to interrupt, challenge, or laugh at others' accounts of their misfortune. So Matlab illness interactions are often adversarial. Patients and their interlocutors compete for the right to speak; they dispute illness meanings. In cases like Yasmin's, listeners might interrupt sufferers in order to halt a downward spiral of despair. But it is not always easy to separate such benevolent motives from others such as the need of listeners, including practitioners, to reduce their own anxiety. Those needs may conflict with the patient's; by interrupting Yasmin, Ali prevented her from putting her own narrative closure on her story of growing despair. And in any case the reshaping of complaints is one of the discursive means that sustain Matlab's hierarchies of power.

Despite the particularity of local meanings of illness and the pluralistic context of health and healing in Bangladesh, analogies exist with Western biomedicine. Although divergent ideologies of language and hierarchy tend to mask the similarities, I find them not only in the forms of practitioner dominance but in the responses of patients. Practitioners cut off the development of important themes when they interrupt patients' narratives. And the hermeneutics of diagnosis can delegitimize patients' words, challenging their authority as self-aware subjects. Biomedical practitioners in Bangladesh and Western societies share a reductionist empiricism that can

alienate patients. If Heykal's verbal challenges to his patients resemble American medical delegitimation of chronic pain, the resemblance stems from the empiricism common to both. Regardless of his level of training, Heykal owes allegiance to a scientific materialism that equates the " 'medically invisible' [with] the imaginary" (Ware 1992:356).

Practitioners in Matlab tend to dominate patients in ways that seem unnecessary to the construction of a healer's charisma or to a placebo response to that charismatic authority. Like their American counterparts, they tend to have an agenda of questions and procedural routines that prevent them from hearing patients' deepest concerns (Paget 1993:124). Despite the differences in theoretical orientation and technology between the herbalist Ali and the American doctor whom Paget describes, the discursive control exercised by both practitioners deprives their female patients of an effective voice.³⁰ Controlling the topic through questioning strategies may make resistance less thinkable if it succeeds in surrounding some patients with the comfort of a known hierarchical structure. But as I measure patients' responses in Matlab—not by explicit reflections in interviews but by their immediate responses to interruption during medical consultations—such asymmetrical control often provokes the discontent that it aims to suppress.

Conflicts, whether at home or in treatment settings, arise not through any ill will directed against *roġi* but out of the inherent threat that illness and complaint pose to tranquility and the social order. Yasmin's expression of despair and her brother's references to exhausting family finances in her treatment foreshadowed her impending death. Sufia's husband sent her away because of her miscarriage. Interlocutors muffled Fatima's and Farhad's complaints with commands, interruptions, and ridicule. Fatima's case reminds us that the problem lies more with pervasive cultural patterns of communication in which the speech of the powerless is cut off than with practitioners as individuals. It was her senior sisters-in-law and not the exorcist who radically compromised her fluency. Indeed some modes of therapy in Matlab seem relatively conducive to patients' telling their stories of illness. Despite the problematics of Ali's consultation with Yasmin, he allowed her to develop her themes with a great deal more freedom than did Heykal. It is not the "bedside manner" of *ċaktar*-pharmacists but their strong *medications* that attract customers. Their busy manner together with their empiricist orientation make them the greater threat to a patient as poet, as author of her life, and as expert in her own subjectivity.

As significant as it is, domination by kin or practitioners does not render patients altogether voiceless or powerless to resist. Patients do at times resist others' attempts to stifle or delegitimize their complaints. Yasmin and Fatima strive against great odds to keep control of discourse topic long enough to present their stories clearly. First Sufia's mother and then Sufia herself struggle for several conversational turns to frame Sufia's problems in their own terms. They try to paint Sufia's reproductive abilities with a gentle touch even when Heykal speaks more bluntly about her miscarriage. And when Heykal tries to put a verb of subjective uncertainty in Sufia's mouth she voices at least one strong affirmation that she knows her own body before acquiescing to his authority.

The challenge the three women present to practitioners and kin is indirect. We see no frontal attack on accepted norms of communication. Each patient struggles to assert limited rights or to increase control incrementally in the interactions in which self and illness are constructed. Patients try to present themselves in the best possible light and to restore a sense of well-being that transcends their status as "patients" in the dual sense, asserting agency by raising their voices. That form of social action is a necessary prerequisite to changing patterns of social practice and specifically humanizing the practice of medicine in Matlab. Sometimes even patients who "can't tell" their problems manage to indicate where broader problems lie.

notes

Acknowledgments. I presented earlier versions of this article at seminars held at the Centre for Development Research, Bangladesh; at the Community Health Division Office of the International Centre for Diarrheal Disease Research, Bangladesh (ICDDR,B) Dhaka; and at the 91st Annual Meeting of the American Anthropological Association. Fieldwork in Bangladesh during 1991–92 was supported by the Institute of International Education and the American Institute of Bangladesh Studies (AIBS). The ICDDR,B gave both logistical and moral support during the period of fieldwork. Many thanks are due to Tony Stewart (AIBS) and Mike Strong and Sushila Zeitlyn (ICDDR,B) for their on-site guidance. Analysis of the data was carried out with the support of a National Science Foundation grant (DBS-9919127). I also want to thank the UCLA Department of Anthropology for funding a pilot study of Bengali household interaction in Los Angeles in 1989–90. I gratefully acknowledge the transcription work of Gazi Nazrul Islam Faisal, Kazi Asadul Mahmum, and Faisal Rahman, and the insights on Fatima's case provided by my students in the UCLA Social Sciences seminar "Language, Power, and Medicine." I also thank Don Brenneis, Carole Browner, Robert Desjarlais, Michael Herzfeld, Jane Huber, John Kennedy, Keith Kernan, Paul Kroskirty, Nancy Levine, Leila Monaghan, and three anonymous *AE* reviewers for their helpful comments on earlier drafts. The present form of the article is naturally my own responsibility.

1. The literal meaning of the title *kabiraj*, from which the adjective *kabiraji* derives, is "king of the verse" (the sacred Sanskrit texts of Ayurveda, such as the Caraka Samita). The heterogeneous array of practitioners called *kabiraj* in Matlab may practice herbalist-Ayurvedic medicine, specialize in exorcism, or combine Islamic spiritualist practice with the dispensation of allopathic remedies.

2. This common ground has been programmatically mapped by Joel Kuipers (1989).

3. Exceptions include M. F. Brown's transcription (1988) of a shamanic healing encounter with an interpretation that faces power very directly, the careful transcriptions of Roseman (1991), and the poetically sensitive transcriptions of Desjarlais (1992). Mary Steedly's analysis of conflict in and over a Karo Batak healing ceremony paraphrases and summarizes discourse (1988), and Laderman's insightful account of healer's discourse (1987) transcribes no *patients'* words. The power-oriented approaches of Morsy (1978) and Taussig (1980) include no transcribed interactions. Reviews of the literature on Western doctor-patient communication are found in Inui and Carter 1985 (clinical research perspective), Cicourel 1985, Mishler 1984, Todd and Fisher 1993, and Waitzkin 1991 (medical sociology).

4. I am not the first to exploit this linguistic-medical pun. See MacIntyre 1977 and Gear et al. 1983.

5. This is not meant to be a denial of the validity of psychodynamic theory or even the therapeutically heuristic value of concepts like "somatization." Certain forms of somatization have been accepted and even validated as disease in most of China's recent history. Theoretical treatments of somatization have acknowledged its value as a coping strategy, perhaps as the only shadow of social protest available to some persons (e.g., Eagleton 1991:135 et passim; Kleinman 1986). Paradoxically, patients' speech may rightly and simultaneously be viewed as distorted and as true to need, true to self, or true to life in a distorted world. It is true of all theories, however, that their use within and influence upon social institutions are as likely to reproduce repressive aspects of the status quo as they are to liberate. For an account of ideology linking Marxian notions of false consciousness to the Freudian unconscious, see Eagleton 1991.

6. The pattern of doctor-patient interaction is linked with gender asymmetry. Ainsworth-Vaughn and others have found that female physicians in North America do not interrupt patients as frequently as their male counterparts. But female kin or practitioners can and do interrupt men in my Bangladeshi data, although females are interrupted more often regardless of the sex of the interrupter. "Few features of language directly and exclusively index gender" because particular correlations are "non-exclusive" (Ochs 1992:340). As is seen in the cases of Farhad, it is not "women's language" but "powerless language" (O'Barr and Atkins 1980) that is typically silenced or cut off.

7. Administrative units in Bangladesh, from least to most inclusive, are village, union, upazila, and district. Beyond Chandpur and Matlab, place names and names of patients are pseudonyms. Unpublished surveys of practitioners, by name and type, are available from J. Chakraborty and M. Sarder, ICDDR,B (Matlab).

8. The embankment is part of the Meghna-Dhonagoda Irrigation Project, a massive ecological intervention with mixed results (Cobb 1993; Huda et al. 1991).

9. Out of a sample of 200 women from my study villages who had visited a free health clinic over two years, half were landless.

10. I am indebted to Indra and Buchignani (n.d.) for this reference. Agreeing that radical changes—from natural disasters to incorporation into the world economy—now result in pauperization for many Bangladeshis and continued threats to women's status, they argue that these very changes can also lead to new opportunities for the activation of "women's entitlements." Their viewpoint challenges the traditional "monolithic despotic" image of patriarchy in Bangladeshi social organization and would substitute a "cooperative-conflict" model in which "struggle, negotiation, and diversity of interests" demythologize patriarchal ideals and avoid reproducing them in "empirical" studies. This is completely congruent with my own emphasis on the constrained agency of actors in conflict.

11. The distinctions between patients and nonpatients or between persons and groups are problematic; I make them for the sake of clarifying my disagreement with Turner.

12. Ishaque 1955 is only one of a number of Bengali literary representations of practitioners who do and do not keep the public trust.

13. Dimock also writes:

All symbolic forms with /æ/ as the base vowel indicate something decidedly unpleasant, either in the nature of the thing indicated or in its effect upon the speaker. Thus, /kætkæt/ indicates a color or combination of colors that is extremely harsh, or a shrewish, loud-voiced woman, /tæktæk/ something annoying or vexing, /pæcpæc/ thick, distasteful mud or dirt, /pænpæn/ a child wheedling or crying for a long time, etc. The effect of any of these forms can be heightened by nasalization. [1989:60]

Nasalization, interestingly, is also associated with the speech of spirits heard when a kabirāj or *fakir* (miracle-working Muslim holy man) acts as a possession-medium and a spirit *jap lawāya* (takes speech). “[The] throat [of the possessed person] began to make a bizarre strangling noise, *hære—hāy—hm’*” (Ishaque 1955:118; nasalization marked in the original Bengali of the novel, transliterated here with a tilde).

14. The unmarked word order of sentences in Bengali or other Indo-Aryan languages is subject-object-verb. The first noun phrase in complaints, however, is not a prototypical subject or semantic agent of the verb but its experiencer. Klaiman (1981) describes the function of this “dative subject” construction as a conventional means to index nonvolitionality. “Dative” subjects in Bengali take genitive case markings.

15. Whereas in the French respect/intimacy system asymmetrical use of *tu* has died out, asymmetry continues in Bengali. It is the sT form that “guardians” use with female patients in some of the transcripts presented here; there it is impossible to separate the indexing of power and of intimacy.

16. Indirect and nonmonetary means of paying exorcists have been mentioned by other observers (Islam 1985:145; Karim 1988:24).

17. The role of family “interpreters” in monolingual medical interviews has only begun to be analyzed. See Massard’s study (1988) of the mediating role of adults taking sick children to practitioners. Hasselkus (1992) points out that not all participation by these kinspeople is disruptive; that is true in the American biomedical encounters she studied as it is in the Bangladesh cases presented here, particularly in the conarration of history by Sufia and her mother (the third case presented in this article).

18. “Weakness” is a polysemous social construction of women’s or men’s experience. The present context does not allow me to expand my treatment of this nosological category (see Wilce 1994:384–392). Fatima’s evidently poor nutritional status indicates that we cannot rule out anemia as an “explanation” for her reference to an experience of being *durba* (weak). Still, the application of that label to women in Bangladeshi discourse is facile, reflecting and constituting a gender ideology. As for a Matlab notion of anemia, my sense is that government nutrition-education campaigns have been grafted onto local knowledge systems, resulting in popular awareness of a condition owing to poor nutrition and conceived of as “lacking blood.” I believe that the relatively cosmopolitan exorcist had such a concept in mind when he told Fatima she must eat better.

19. Further interpretive work on this phenomenon is needed. The boba experience can be explored as (1) a rejection of normative discourse patterns; (2) a dramatization of the message “I can’t speak freely”; and (3) a retreat to a preobjective and preverbal developmental stage.

20. In fact, the distribution of the verb *pār* (can) among the participants in the original exorcism consultation is revealing. It is used eight times, twice by kabirāj Jahangir and six times by Fatima. Whereas all six of Fatima’s usages are accompanied by *nā* (negating the verb, thus expressing inability), Jahangir never says *pārī nā* or construes the outcome of this consultation to reflect inability on his part. My later encounters with him were friendly; he seems unaware that his clients feel that Fatima’s problem is unresolved. Moreover, he always answered my questions about his further exorcism activities with an embarrassed smile and a statement to the effect that no one had called on him recently.

21. As in German, rural Bengali phrases referring to body parts may include the definite article suffix /-tā/ as in *āḍi-tā* (line 2B), or the demonstrative *ay* (that) rather than a possessive pronoun as in English. But it is also possible in Bengali to use a possessive pronoun. My sense is that use of the article characterizes the complaints of rural, poor, illiterate, and female patients, while first-person possessive pronouns are more characteristic of urban, middle-class, educated, and male patients. Further analysis of my recorded corpus and perhaps new data collection will be needed to test that sense.

22. My field assistant, Faisal, understood Yasmin to say *muchon* (wiping out, erasure), but my consultant Asad thought she was mispronouncing *mucrāna* (knotting, cramping). It was originally Faisal’s transcription that led me to believe Ali was cutting off Yasmin’s most poignant expression of despair. Asad, contemplating the possibility that Yasmin was saying “*mucrāna*,” argued that this entailed her development of the *abdominal pain theme whereas the more existential comment did not. But, unable to deny that she says it is her jiban* (life) that is subjected to mucrān/muchon, he is willing to allow that she has extended the discourse beyond his question. The admitted lack of unanimity aside, it is clear to the three of us that Ali does not allow her to develop this point, one that is important to her.

23. Jahangir and Ali share with *hātuli dāktar* (hands-on doctors) like Heykal an apprenticeship training.

24. Whereas in Dhaka owner, pharmacist, and physician are often three distinct individuals in a business partnership, in the Matlab area they are more commonly one.

25. It is predictable that rural Bangladeshi men will divorce women who evince any difficulty in conceiving or bearing children or will divorce even those women who bear children but no sons.

26. Sufia’s mother is alluding here to an earlier visit to Heykal that I had not observed.

27. The “=” signs at the end of line 11 and the beginning of line 12 indicate that the two utterances are “latched,” with only a minimal pause between them. Line 11 itself is a sort of interruption in which Heykal completes the sentence Sufia’s mother was unwilling to complete. Thus her utterance in line 12, closely following Heykal’s insertion, continues where she left off but jumps over the sensitive matter of the miscarriage itself.

28. Upon hearing of Heykal's use of *anubhab* in this situation, one informant expressed the opinion that it was Heykal whose approach was too subjective; he said the *daktar* should have ordered an x-ray to remove doubt. Heykal's reticence to touch the woman is, however, considered morally, if not medically, virtuous.

29. In the folk taxonomy of enteric conditions, *amaśa* refers to diarrhea with blood, and never to cholera. ICDDR,B considers *amaśa* to correspond with shigellosis. Through no fault of ICDDR,B, the author became an unwilling participant in their ongoing research into this disease and benefited from the care they provide in their Matlab hospital.

30. The gender of the practitioners might usefully be distinguished from both the gender role the practitioner plays and the practitioner's class status. One of the most abrasive and insulting practitioners of medicine I have recorded is a woman. All her patients are poor women, separated from her by a great class gap. In other social contexts—and particularly when she is with men—she is quite polite, although she retains a uniquely forceful manner. Likewise it may be that Fatima perceives her sisters-in-law to be playing a male role when they ridicule her. Their authority over her, after all, is derived through Fatima's husband's elder brothers.

references cited

- Ainsworth-Vaughn, Nancy
1992 Topic Transitions in Physician-Patient Interview: Power, Gender, and Discourse Change. *Language in Society* 21:409–426.
- Bagchi, Tista
In press Bengali Writing. In *The World's Writing Systems*. Peter T. Daniels, and William Bright, eds. Pp. 393–402. New York: Oxford University, 1996.
- Bhattacharyya, Deborah
1986 Pagalami: Ethnopsychiatric Knowledge in Bengal. *Foreign and Comparative Studies/South Asian Series*, 11. Syracuse, NY: Maxwell School of Citizenship and Public Affairs.
- Briggs, Charles
1992 "Since I Am a Woman, I Will Chastise My Relatives": Gender, Reported Speech, and the (Re)production of Social Relations in Warao Ritual Wailing. *American Ethnologist* 19:337–61.
- Brown, Michael Fobes
1988 Shamanism and Its Discontents. *Medical Anthropology Quarterly* (n.s.) 2:102–120.
- Cicourel, Aaron
1985 Doctor-Patient Communication. In *Handbook of Discourse Analysis*, Vol. 4: Discourse Analysis in Society. Teun A. Van Dijk, ed. Pp. 193–202. London and Orlando, FL: Academic Press.
- Cobb, Charles E.
1993 Bangladesh: When the Water Comes. *National Geographic* 183:118–134.
- Davis, Kathy
1993 Nice Doctors and Invisible Patients: The Problem of Power in Feminist Common Sense. In *The Social Organization of Doctor-Patient Communication*. 2nd ed. Alexandra Dundas Todd and Sue Fisher, eds. Pp. 243–265. Norwood, NJ: Ablex.
- Desjarlais, Robert R.
1992 Body and Emotion: The Aesthetics of Illness and Healing in the Nepal Himalayas. Philadelphia: University of Pennsylvania.
- Dimock, Edward C.
1989 Symbolic Forms in Bengali. In *The Sound of Silent Guns and Other Essays*. Pp. 52–61. Delhi: Oxford University.
- Eagleton, Terry
1991 *Ideology: An Introduction*. London, New York: Verso.
- Fabrega, Horacio, Jr.
1990 The Concept of Somatization as a Cultural and Historical Product of Western Medicine. *Psychosomatic Medicine* 52:664.
- Falk, Jane
1979 *The Conversational Duet*. Ph.D. dissertation, Princeton University.
- Fisher, Sue, and Susan B. Groce
1990 Accounting Practices in Medical Interviews. *Language in Society* 19:225–250.
- Frake, Charles
1964 The Diagnosis of Disease among the Subanon of Mindanao. In *Language in Culture and Society*. Dell Hymes, ed. Pp. 193–211. New York: Harper and Row.
- Gear, Maria Carmen, Ernesto Cesar Liendo, and Lila Lee Scott
1983 *Patients and Agents: Transference-Countertransference in Therapy*. New York and London: Jason Aronson.
- Good, Byron, and Mary-Jo Delvecchio Good
1981 The Meaning of Symptoms: A Cultural Hermeneutical Model for Clinical Practice. In *The Relevance of Social Science for Medicine*. Leon Eisenberg and Arthur Kleinman, eds. Pp. 253–279. Dordrecht, The Netherlands: D. Reidel.

- Habte, Demissie, ed.
1990 Annotated Bibliography of ICDDR,B Studies in Matlab, Bangladesh. Specialized Bibliography Series, 14. Dhaka: International Centre for Diarrheal Disease Research, Bangladesh.
- Hashemi, Syed M., and Sidney Schuler
1992 Disparate Responses to Men's and Women's Health: Evidence from Rural Bangladesh. Paper presented at the 91st Annual Meeting of the American Anthropological Association, San Francisco.
- Hasselkus, Betty Risteen
1992 The Family Caregiver as Interpreter in the Geriatric Medical Interview. *Medical Anthropology Quarterly* (n.s.) 6:288–304.
- Haynes, Douglas, and Gyan Prakash, eds.
1991 *Contesting Power: Resistance and Everyday Social Relations in South Asia*. Berkeley, Los Angeles: University of California.
- Huda, Abdul, Muhammad Huq, and A. I. Bhuiyan
1991 The Bangladesh Meghna-Dhonagoda Irrigation Project. *Public Administration and Development* 11:215–18.
- Hufford, David
1982 *The Terror That Comes in the Night: An Experience-Centered Study of Supernatural Assault Traditions*. Publications of the American Folklore Society, n.s., 7. Philadelphia: University of Pennsylvania.
- Indra, Doreen Marie, and Norman Buchignani
n.d. *Uthuli Residence as a Response to Environmentally-Forced Migration in Kazipur, Bangladesh*. Unpublished manuscript.
- Inui, Thomas S., and William B. Carter
1985 Problems and Prospects for Health Services Research on Provider-Patient Communication. *Medical Care* 23:521–38.
- Ishaque, Abu
1955 *Surya-Dighal Bari. (Sun-Crossed Homestead)*. Dhaka: Nowroj Kitabistan.
- Islam, Mahmuda
1985 *Women, Health, and Culture: A Study of Beliefs and Practices Connected with Female Diseases in a Bangladesh Village*. Dhaka: Women for Women.
- Jefferson, Gail
1980 On "Trouble-Premonitory" Response to Inquiry. *Sociological Inquiry* 50:153–185.
1981 The Rejection of Advice: Managing the Problematic Convergence of a "Troubles-Telling" and a "Service Encounter." *Journal of Pragmatics* 5:399–422.
- Karim, Anwarul
1988 *The Myths of Bangladesh*. Kushtia. Bangladesh: Folklore Research Institute.
- Klaiman, Miriam H.
1981 *Volitionality and Subject in Bengali: A Study of Semantic Parameters in Grammatical Processes*. Bloomington: Indiana University Linguistics Club.
- Kleinman, Arthur
1986 *The Social Origins of Distress and Disease*. New Haven, CT, and London: Yale University Press.
1992 Pain and Resistance: The Delegitimation and Relegitimation of Local Worlds. In *Pain as Human Experience: An Anthropological Perspective*. Mary-Jo Delvecchio Good, Paul E. Brodwin, Byron J. Good, and Arthur Kleinman, eds. Berkeley: University of California Press.
- Kuipers, Joel C.
1989 "Medical Discourse" in Anthropological Context: Views of Language and Power. *Medical Anthropology Quarterly* (n.s.) 3:99–123.
- Laderman, Carol
1987 The Ambiguity of Symbols in the Structure of Healing. *Social Science and Medicine* 24:293–301.
- Lazarus, Ellen S.
1988 Theoretical Considerations for the Study of the Doctor-Patient Relationship: Implications of a Perinatal Study. *Medical Anthropology Quarterly* (n.s.) 2:34–58.
- MacIntyre, Alasdair
1977 Patients as Agents. In *Philosophical Medical Ethics*. Stuart F. Spicker and H. Tristram Englehardt Jr., eds. Pp. 197–212. Boston: D. Reidel.
- Massard, Josiane
1988 Doctoring by Go-Between: Aspects of Health Care for Malay Children. *Social Science and Medicine* 27:789–797.
- Mishler, Elliot G.
1984 *The Discourse of Medicine: Dialectics of Medical Interviews*. Norwood, NJ: Ablex.
- Morsy, Soheir
1978 Sex Roles, Power, and Illness in an Egyptian Village. *American Ethnologist* 5:137–150.
- Nichter, Mark
1981 Idioms of Distress: Alternatives in the Expression of Psychosocial Distress: A Case Study from South India. *Culture, Medicine, and Psychiatry* 5:379–408.
- O'Barr, William M., and Bowman K. Atkins
1980 "Women's Language" or "Powerless Language"? In *Women and Language in Literature and Society*. S. McConnell-Ginet, Ruth Borker, and Nelly Furman, eds. Pp. 93–110. New York: Praeger.

- Ochs, Elinor
1992 Indexing Gender. *In Rethinking Context: Language as an Interactive Phenomenon*. Alessandro Duranti and Charles Goodwin, eds. Pp. 335–358.
- Paget, Marianne A.
1993 On the Work of Talk: Studies in Misunderstandings. *In The Social Organization of Doctor-Patient Communication*. 2nd ed. Sue Fisher and Alexandra Dundas Todd, eds. Pp. 107–126. Washington, DC: Center for Applied Linguistics.
- Papanek, Hanna
1990 To Each Less Than She Needs, from Each More Than She Can Do: Allocations, Entitlements and Value. *In Persistent Inequalities: Women and World Development*. Irene Tinker, ed. New York and Oxford: Oxford University Press.
- Population Crisis Committee
1988 Country Rankings of the Status of Women: Poor, Powerless, and Pregnant. Briefing Paper 20. Washington, DC: Population Crisis Committee.
- Putnam, Samuel M., and William B. Stiles
1993 Verbal Exchanges in Medical Interviews: Implications and Innovations. *Social Science and Medicine* 36:1597–1604.
- Reiser, Stanley
1978 *Medicine and the Reign of Technology*. Cambridge: Cambridge University.
- Rich, Eugene C., Terry W. Crowson, and Ilene B. Harris
1987 The Diagnostic Value of the Medical History: Perceptions of Internal Medicine Physicians. *Archives of Internal Medicine* 147:1957–1960.
- Roland, Alan
1988 *In Search of Self in India and Japan: Toward a Cross-cultural Psychology*. Princeton: Princeton University Press.
- Roseman, Marina
1991 *Healing Sounds from the Malaysian Rainforest: Temiar Music and Medicine*. Berkeley: University of California Press.
- Scarry, Elaine
1985 *The Body in Pain: The Making and Unmaking of the World*. New York and Oxford: Oxford University Press.
- Steadly, Mary Margaret
1988 Severing the Bonds of Love: A Case Study in Soul Loss. *Social Science and Medicine* 27:841–56.
- Tannen, Deborah
1979 Processes and Consequences of Conversational Style. Ph.D. dissertation, University of California, Berkeley (Ann Arbor, MI: University Microfilms).
- Taussig, Michael
1980 *The Devil and Commodity Fetishism*. Chapel Hill: University of North Carolina Press.
- Todd, Alexandra Dundas, and Sue Fisher, eds.
1993 *The Social Organization of Doctor-patient Communication*. 2nd ed. Norwood, NJ: Ablex.
- Turner, Victor W.
1964 An Ndembu Doctor in Practice. *In Magic, Faith, and Healing: Studies in Primitive Psychiatry Today*. Ari Kiev, ed. New York: The Free Press.
- Waitzkin, Howard
1991 *The Politics of Medical Encounters*. New Haven, CT: Yale University Press.
- Ware, Norma
1992 Suffering and the Social Construction of Illness: The Delegitimation of Illness Experience in Chronic Fatigue Syndrome. *Medical Anthropology Quarterly* (n.s.) 6:347–61.
- Waxler, Nancy E.
1980 The Social Labeling Perspective on Illness and Medical Practice. *In The Relevance of Social Science for Medicine*. Leon Eisenberg and Arthur Kleinman, eds. Pp. 283–306. Dordrecht, The Netherlands: D. Reidel.
- West, Candace, and Don H. Zimmerman
1975 Sex Roles, Interruptions and Silences in Conversation. *In Language and Sex: Difference and Dominance*. Barrie Thorne and Nancy Henley, eds. Rowley, MA: Newbury House.
1983 Small Insults: A Study of Interruptions in Cross-Sex Conversations between Unacquainted Persons. *In Language, Gender, and Society*. Barrie Thorne, Cheris Kramaræ, and Nancy Henley, eds. Pp. 102–117. Rowley, MA: Newbury House.
- Wilce, James M.
1994 Repressed Eloquence: Patients as Subjects and Objects of Complaints in Matlab, Bangladesh. Ph.D dissertation, University of California, Los Angeles.

submitted October 1, 1993
revised version submitted March 23, 1994
accepted May 22, 1994