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'At the Entrance of the Kidney Transplantation Ward': Narrating Ethnographic Anxieties and Negotiations

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Abstract: *The self or subjective experiences of the ethnographer are essential components of the ethnographic text. Ethnographic studies of disease, aliment and bodily suffering, and the fear of imminent death, resulting from any chronic disease like kidney failure cannot rule out the fact that the ethnographer is deeply implicated in the experiences narrated and represented in the ethnographic text. In the process of gaining knowledge, the ethnographer is subject to experiences which generate personal and ethical anxieties as result of encounter with the characteristic experiences of the ailing person and the immediate nexus of inter-personal relations, including family and kinship relations, surrounding the person. The personality of the ethnographer in such studies is very crucial for such fields of experience throw up challenges for documenting the unique nuances of the experiences characteristic to it. In this paper I ruminate as an ethnographer on my experiences of encountering the field of kidney failure, dialysis and transplantation and the anxieties I had to encounter during my fieldwork and how I sought to negotiate or resolve them. This paper is a reflexive engagement with the suffering of people with kidney failure and those immediately responsible as care-givers as much as it is a narrative about my personal negotiations with the anxieties such study generates.*

Keywords: Ethnography, humanness, reflexivity, kidney failure, dialysis, kidney transplantation ward, bodily suffering, pain, ethnographic anxieties.

Introduction

Doing ethnographic research calls for recognizing the humanness of researcher as much as it involves recognizing the humanness of the others – the subjects of research. A research which chooses to engage experiences of life and death, and the struggle for survival in the face of organ failure and the search for a transplantable donor organ, has to particularly begin by recognizing the non-negotiability of humanness of the researcher. This stance however has nothing to do with discounting the subjects of research. Although protocols of research would require the researcher to take a measured stance with regard to the field and the informants or the subjects therein but the course of events, when one begins to engage the field, may not allow the research to fully conform to the received canons and accepted protocols of doing research. This slippage from conformity needs to be understood in relation to the humanness of both the researcher and the field thus constructed for research.

When I use the term human, I deploy it in terms of fallibility (Ricouer 1993). Institutional scientism and its incumbent protocols of academic activity, conceives of research as a time-bound and systematic, goal-oriented effort. Doing research not only involves grabbing a PhD berth for oneself at a university, it also involves providing a blueprint for conducting and completing the research on time. Ideally the timeline proposed in the research proposal ought to determine not only the research but also the researcher's concept of present and future, his or her life in short. However even the most rational-instrumental and professional approach to research and life during research cannot contain the excesses research engenders and the conversation that entails between the research and the researcher's life. Accepted protocols demand linear flow or transition from one stage of the research to the other but life, as it is constituted of multiple structured role-performances in relation to emergent situations, rules out all possibility of bracketing that specific portion of life where the individual is a researcher, attempting to obtain a degree, from all the functions, obligations and worries life contains in general. Institutionally funded and guided research cannot suspend life's flow and its inherent dynamics. Conversations between the two are bound to occur. Any research that seeks to retain this humanness and not give in to the instrumentalism of scientific method and the protocols of scientific presentation of data ought to take this conversation seriously – engage and document it.

To recognize the humanness of the researcher and to humanize the research is a move towards establishing the impossibility of a humane research that does not take into account the life and life-trajectory of the researcher. The human fallibility of the researcher, the inability to bracket life, does not pose an obstacle to research; rather it offers materials that render research more close to the mundane experiences of life, thereby making it more grounded in reality. Research does not espouse the life of the researcher to its detriment. For an ethnographer of life, death and struggle for survival and the related human experiences of crisis, his or her own life history, its length, course and events provide new dimension for a reflexive (Gouldner 1970; Bourdieu and Wacquant 1992) engagement with the problem at hand.

My tryst with the experiences of organ failure, donation and transplantation began in mid-2015 as a research student and in the March of 2017, my father's eldest brother passed away after several months of struggle with kidney failure. My encounter with his pain and suffering, and that of the immediate family surrounding him, brought me closer to the set of experiences I was trying to ethno-graph or narrativize through my research. The encounter was obviously unfortunate and accidental – something I did not know would happen, but shaped my perception of the problem and the field I was trying to construct and engage in most foundational ways.

Of personal tragedy and an accidental beginning

It was an early winter morning of February 2017, when my uncle was admitted to the S.S.K.M.[1] hospital with severe breathing trouble and fluid retention in his body. He was suffering from kidney ailment for last seven, eight years. The situation gradually became more critical towards the end of 2015 when his nephrologist told my cousin brothers that his kidneys are damaged and would soon be requiring dialysis. My aunt and brothers were very worried as a result.

Although my uncle was employed with a well-known private firm, he was not financially stable in the post-retirement phase. The recurrent, monthly medical expenses were already huge. Much of the money that he had received at retirement got exhausted in last seven, eight years owing to huge medicine costs and recurrent blood tests. His initial treatment began at the out-patient department of a private hospital, which was financially manageable at that point of time. When towards the end of 2015, his nephrologist said that total kidney failure was imminent and dialysis was the only resort, worries aggravated within the family. The issue was two-pronged: money and time. On the one hand, my aunt and brothers were worried that they would not be able to continue treatment at the private facility because dialysis there is too expensive. On the other hand, they could not finalize on a government hospital, where the dialysis is offered for free but there is a huge queue, and patients are asked to visit the dialysis centre at odd hours. Since my cousin brothers are in the private sector, they were certain that they would not get recurrent leaves to accompany my uncle for dialysis.

This sense of imminent crisis continued for close to another year and towards the end of 2016, averting dialysis became impossible. My aunt and brothers decided to get my uncle enrolled for dialysis in M. R. Bangur hospital in South Kolkata, which is close to their residence. The first round of dialysis consisted of three sessions with one-day gap in-between for the first two weeks and then for the next two weeks with dialysis sessions with three days' gap. This was an immensely draining period for them. I earnestly wanted to help them by substituting one of my brothers for at least a couple of dialysis sessions but could not do so due to my work obligation. I however made an attempt to help them in ways that would at least take care of associated crises at the home front. My aunt, who was already a senior citizen by then, always accompanied my uncle for the dialysis sessions which lasted for three or four hours, until he was discharged. However, she could not accompany my uncle if the session was scheduled at mid-night or beyond that, as she had to attend my elder cousin brother's sons, of whom the elder one was then barely seven years of age and the younger was only five, who were left at the disposal of my aunt after their parents abruptly separated. We, I and my mother, were more than eager to take care of the children when my aunt accompanied my uncle for the day-time dialysis sessions. In fact, she eagerly accepted our proposal, as she wanted to substitute, at least partially, one of her sons, who had decided to accompany my uncle as the main attendant for that day. We volunteered to take care of the children during the night, in case my aunt had to accompany my uncle for the night-time sessions but she chose not to bother us. This continued for one month and after this first round of dialysis at the South Kolkata government hospital doctors informed that my uncle was comparatively better than the past and the gap between two sessions could be increased to five days. However, by appearance, there was clear indication that his overall health condition had deteriorated. He looked exhausted and emaciated.

Long-term dialysis is no simple an experience, especially if the patient has resorted to the government facility for the procedure. There is not only a challenge of collectively working out of the logistics for receiving dialysis service from a government hospital, a whole lot of caution and care is required at the home front owing to the manifold restrictions on food and fluid intake. Where employing a twenty-hour attendant is not possible due to financial constraint, there are tangible pressures of managing pre and post-dialysis care. My aunt was worst hit in this regard. Not only my uncle was weak and feeble, he sometimes failed to go the toilet and was mostly bed-bound. My aunt had to attend to his problems, dispose his urine, clean his lower body and sometimes wash the faecal stains on his *lungi*[2] Although dialysis in general improves a patient's overall health, in his case, there were clear signs of degeneration, may be due to the age factor. He was already mid-70s by then.

In the winter of 2017, towards the end of January, complications began to reappear. He had severe breathing issues. His haemoglobin levels dropped drastically, protein and albumin levels too and there was abnormal fluid retention in his body. My brothers realized that hospitalization was unavoidable. Admitting him in a private hospital was no option; therefore, they decided to admit him to the S.S.K.M. hospital in Kolkata. Dialysis resumed at the S.S.K.M. hospital and was done on the alternate days. On one occasion I accompanied him to the dialysis centre, when my cousin brothers were not around due to occupational compulsion. He was there in the hospital for about a month. He had returned home in February but dialysis continued. He passed away in

March, 2017 due to chronic kidney disease and gradual multi-organ failure.

Encountering suffering anew

In October 2017, I returned to S.S.K.M. hospital. In the previous visit to the hospital, there was a sense of purpose, although for a reason I have nothing to feel happy about. Visiting S.S.K.M. hospital back then, on and off, was more of an inner compulsion, an emotional necessity. Now that I was there for gathering information for my research – the instrumental-utilitarian impetus behind the visit made me feel uncomfortable. I had a strange feeling that I was being observed by the people within the hospital space, of which I have no concrete evidence though. Precisely because I did not share the common concern which other visitors had, I felt of myself as an outsider and an object of suspicious gaze. I felt I had suddenly intruded into a space, with a characteristic experience, for visiting which I did not have the legit purpose others had, and therefore the initial attempts at wandering that is so crucial for an ethnographic foray, would do no good I had realized, because people there were too steeped in their own existential concerns, and I went practically unnoticed. The dynamic between the perception of being observed with suspicious gaze and being rendered invisible or physical presence going unnoticed – as if my presence did not matter, made me ponder over multiple questions. At the ethical front, I thought that the very fact that I did not share the same concern and compulsion behind inhabiting the space, I should rethink my reasons behind doing ethnographic fieldwork there. At the personal front, I thought of myself as completely lacking the skills of a capable ethnographer of making his presence at least minimally felt at the ethnographic site, much necessary for sparking conversations with people. After days of wandering here and there, in the known and unknown recesses within the expansive government hospital space, I realized that this directionless wandering about, would probably help me gradually overcome the hesitation of being in a space where I should not be, ethically speaking, but it would yield no concrete data for my research on organ failure, donation and transplantation. I thought of photographing not the premises *per se* but the movements and activities of people therein, but that too emerged as a great challenge. Photographically capturing other people unawares seemed dangerous for many reasons and convincing them about being a part of my study appeared equally difficult.

I soon decided that I have to station myself somewhere to observe people. A government hospital is a populous space and people are constantly moving – some trying to do what they are meant to do and others trying to get their work done. I understood that describing the ethnographic scene would require me to fix my gaze, limit my frame and then observe who and what enters the scene, how, when, with whom, under what conditions and in what capacities. I therefore adopted a dramaturgic approach (Goffman 1990) but I understood that I cannot simply be an observer or an interviewer, capturing the nuances of the ethnographic scene would also require falling back upon subtle visual and sonic resources. While in my previous encounter with the hospital space, when I was a participant and observer at the same time, with my participatory role being primary and the observatory role being emergent, here I was now supposed to be a full observer for the sake of my research. But I had to simulate participation, because I did not want to divulge my psychic and corporeal vulnerability at being a complete outsider to the set of characteristic experiences connected to the hospital space. I could not adhere to the canonical confidence of an objective social scientist and paralyzing hollowness crept in.

I finalized drawing upon my experience from the previous encounter with the hospital space; I just have to go one floor above, at the entrance of the kidney transplantation ward, if not inside. Though the objective was far less ambitious than required, it appeared as a more humane and practical approach for the time being. Personal-mental barriers in ethnography are huge, and an act as simple and unproblematic as climbing twice a dozen of stairs to go up and fix the gaze at a particular location, observe and listen to what unfolds, involved negotiating the challenge of my own vulnerability and inertia. The perception of threat derived not so much from the relatives and attendants of the patients but from the personnel who manned the hospital space in sentinel roles. This is not to say that the relatives and attendants of the patients do not enact surveillance roles or appear intimidating or overtly and disturbingly curious, which they often do, as my previous experience suggests, but it seemed to be a more workable strategy to locate myself in the least possible disputed position viz-a-viz the patients' relatives and attendants, and the hospital personnel in order to ease the hierarchical barrier to the flow of information, which would have been a concern had I resorted to the medical practitioners or the bureaucrats for help. As my aim was to engage lived struggles related to kidney failure, my strategy was to locate myself at the bottom of the hierarchy viz-a-viz those at the helm of affairs, in the waiting area or at the staircase, rather than sit in the Head of the Department's chamber, however difficult, awkward and uncertain it may be.

Amidst the problem finally

The space in front of the kidney transplantation ward in the fifth floor is in sharp contrast to the dialysis centre just below. It is brightly lit up and much cleaner and well maintained compared to the waiting area in front of the dialysis unit. Sanitation and hygiene issues are taken care of seriously, as transplant recipients are subject to risk of deadly infections. When I first saw the transplantation ward it was comparatively newer than the dialysis centre and did not have a waiting area, as gathering in front of the opaque door of the ward was strictly prohibited, apart from the single visiting hour from five to six in the evening, with strict restriction on the entry of more than one visitor per day. Visitors in small numbers assembled every evening in front of the transplantation ward, which houses the recovery rooms in which recipients of transplantation are kept in observation in the post-transplantation phase, if fortunately, they have not been lodged in the Intensive Care Unit for a long time for some critical issue. Because the patients are under heavy immune-suppression, there is restriction on the number of visitors. Infected people may transmit infections to the transplant recipients in the vulnerable post-transplantation phase.

Hospital staff is careful about frequently sanitizing the space. The ward personnel are also strict about maintaining silence and preventing any gathering in the area. During my earlier visit to the Nephrology building at the S.S.K.M. hospital, I had seen nurses and ward boys behaving strictly with the outlaws who seek to have a glance of their patients at odd hours. From the point of view of the ethnography I was trying to conduct, the biggest challenge was to get a scope to speak to people confronting the situation, both as recipient and as immediate care-givers. First of all, it was impossible to have a glimpse of the recipients and therefore I had to rely on the narratives of family members, relatives and friends. Secondly, the family members and friends were available only for an hour every day, thereby making the field I was trying to make sense of strictly time-bound. On top of that, compared to the dialysis centre below, were there was a marked relaxation in the norms of conduct, as attendants had to accompany the patients all the time and sometimes there were more than one and nobody really bothered, just one floor above, at the entrance of the kidney transplantation ward, patients' family members did not even dare to appear in front of the outer collapsible gate, before or after the visiting hour. But I noticed that a few anxious family members often hid themselves by sitting on the staircase leading to the floor below. Doctors and hospital staff generally used the elevators to move up and down. Sitting or standing on the staircase appeared as a safer option for many of them. Like others, I too was initially scared of presenting myself in person in front of the main entrance, where very few visitors, mostly family members and close friends, assembled every day. I thought of it as pointless to show the hospital personnel my research scholar's identity card and the request letter by my supervisor to all concerned who could help me by providing information. Through my personal exposure to the world of ailment and suffering, I had realized that there is no possible way in which one could ask an ailing person or the people suffering around him or her to respond to a set of questions framed to gain access to their characteristic experiences. Asking for information by then had begun appearing to me as an unethical exercise, especially if one is interested in immediate experiences relating to life, death and the imminent fear of death-induced separation. Structured interview appeared to be a futile method – too closed to grapple with sensitive experiences of the kind I am trying to engage and therefore I chose to rely on free-floating conversation and observation coupled with reliance on sonic resources for constructing my rendering of the ethnographic scene under investigation.

Stationing the self

With these anxieties and tentative resolutions in mind I decided to sit silently on the staircase and observe and listen to what unfolds in the scene – a method indigenous to the hospital space, derived partially from the anxious family members of ailing persons. I was convinced I would fail to collect or garner data that would help me write a research monograph fully based on ethnographic details but given the fact that I was thoroughly uncomfortable encroaching into a space to which I did not really belong experientially, I deliberately chose to station myself as an observer-cum-listener on the staircase, which was markedly liminal (Turner 1964) – a bridging space which connected the dialysis centre and transplantation ward of the Nephrology building, yet they represented spaces where actions and activities unfolded in diametrically opposing ways. More so because, it was here that I could pass myself off as an attendant of an ailing person undergoing dialysis. Although in the transplant discourse across the world, it is a highly voiced claim that transplantation costs are much lesser compared to cost of long-term dialysis of chronically ill patients but in developing countries like India, where transplantation is yet to be made available to the public for free or at subsidized rates through government hospitals, many patients suffering from kidney failure have to undergo dialysis either for free in government hospitals or at huge expenses in private hospitals, until they finally perish. Most of the patients who undergo dialysis in the floor below, their family members and relatives rarely hope to move to the floor above, for them it represents a zone of impossibility even though it stands for the positivity of healing and cure through transplant science and technology. Only a few, according to the official priority considerations of the waiting list, are fortunate enough to reach the floor above, and contemplate a life beyond kidney failure, unless the negativity associated with organ rejection descends and upsets everything.

When days had elapsed in between but I was not able to strike a conversation with anybody, I thought of seeking help from *Debu* (name changed), a low rank contractual hospital staff who had helped us a lot when my uncle was admitted in the hospital. Initially I thought I would not be able to contact *Debu* given the fact that many today keep changing their phone numbers time and again. When I started looking for *Debu's* contact on my phone, there was a sudden bout of anxiousness that would not be able to find his number. When I started searching his name, I found his phone number saved as, 'Debu SSKM'. I knew of *Debu* as a jovial man and did not bother much before calling him up but I was tensed about how to make him recollect who I was. When I introduced myself, I do not know whether he was able to remember my uncle, aunt and cousin brothers, because it was through them that I came in contact with him. His reply, whether he exactly remembered them or not I do not know, was very positive. When I told him about my research and what I intend to do, he was comfortable with the idea of introducing me to his co-workers in the kidney transplantation ward. As I was in a hurry and wanted to get started with the exercise as early as possible, I requested him that I would reach the hospital premise the very next day, at any time of his convenience, and it would be kind of him if he could introduce me to at least someone who could guide and help me proceed with my research.

Next day after reaching the hospital premises I gave a call to *Debu*, who asked me to come in front of the Nephrology building within fifteen, twenty minutes. Since I had already reached the hospital premises I waited in front of the main gate until *Debu* arrived. It was the visiting hour, and there were few people around when *Debu* accompanied me to the transplant ward. He gave a call to a man he referred to as *Sudeb Da* (name changed), a man in late forties or early fifties, who worked in the Nephrology building. *Debu* vaguely introduced me to the person. When I realized there are possibilities of misrepresentation I intervened hastily to tell him what I intended to do. This is because *Sudeb Da* seemed to be in a hurry. After listening to me, he appeared unsure about the way in which he could help a person studying people who have kidney disease. I added that in case it was not possible to speak to the patients, it would be enough if I am able to speak to their family members and close relatives. Initially I had this construct that I would have to speak to the transplant recipients, but with growing familiarity with their medical condition, and the barriers to free interaction with the recipients it throws up, especially if one is interested to speak to them within the hospital premises, I realized the impossibility of the approach. 'Beggars cannot be choosers' I thought, and for the time being the strategy was to at least speak to someone, who is closely exposed to the set of characteristic experiences I was trying to engage or at least be allowed without suspicion or threat to be present in front of the transplantation ward. Later on I found that this strategy yielded much more in terms of 'thick' narratives (Geertz 1973), as compared to the scenario where I would have spoken to the recipients, which is risky for them and therefore ethically reprehensible.

When this entire persuasion session was going on, with *Debu*, my aide from the field, and the potential interlocutor, *Sudeb Da*, at one corner of the landing between the fourth and fifth floor, I noticed a man in fifties, having a fair, round face, looking inquisitively at us and trying to listen to our conversation with attention. When we suddenly exchanged a glance, I noticed that he was giving a faint smile, to which I responded immediately, as I was desperate that day to have at least developed some contact. The smile, though faint, was a positive reaction, and I grabbed the opportunity.

Conversations begin, but how

Seeing me smile, he came forward and asked me: 'Are you a researcher?' Upon finding someone who understood who I was, I immediately replied: 'Yes, I am working on organ transplantation for my PhD. I have come here to speak to people to collect some information.' I had used the word *gobeshona* (the Bengali word for research) a few times in my futile effort to make *Sudeb Da* understand, why I needed his help. But *Sudeb Da* seemed unfamiliar with the term when I first uttered the word but later on I realized that he thought of research as the medic's pursuit when he asked me, in a slightly rude manner: 'Are you a doctor that you are doing research? Speak to the Head of the Department, he can help you, I cannot do anything.' When the round faced, fair complexioned man intervened, *Sudeb Da* immediately disappeared from the scene, giving a look that he cannot waste time in irrelevant conversations. Seeing my face turn pale at *Sudeb Da's* reaction, *Debu* looked at me reassuringly and requested the man approaching us, if he could be of help to me in some way. The man seemed already interested to interact with me. He introduced himself as *Rajesh Ganguli* (name changed), a businessman who runs a popular catering service in *Birati* in *North 24 Parganas*.[3]

From that evening onwards to the next four, five days, *Rajesh Ganguli* was constantly around, knowingly and unknowingly helping me cope with the sense of loneliness I had crept in when I started my ethnographic fieldwork at the Nephrology building of the hospital. Personality factor in ethnographic studies is very crucial, not being a kind of a person who is very confident in striking conversation with unknown people, even when I was acutely aware of the fact that I somehow needed to do this for my research, to make things work one way or the other, I needed someone to depend upon, conversations with whom would help me coalesce with the context I was trying to engage, camouflage and overcome the overbearing feeling of foreignness. Such conversations are very crucial speaking from the research method point of view for these help the observer overcome the foreignness of his or her presence or outsider status, and engage in conversations 'as if' he or she were one of those attendants waiting outside the kidney transplantation ward, having no distinct mark or impact as a researcher on the context and the nature of interaction that unfolded there, while maintaining an empathetic attitude towards the psychological and corporeal suffering of people, yet remaining critical, and acutely aware of the fact, that unless the same misfortune befalls him or her, this entire experience would amount to the writing of a thesis or an ethnographic monograph for the award of an academic degree or the publication of a book.

Conclusion

On the basis of the many encounters with kidney failure, dialysis and transplantation that ensued thereafter, I have arrived at few resolutions about anxieties and negotiations involved in carrying out ethnographic studies of hospital space and the individual-specific experiences of pain and suffering related to kidney failure.

In such studies the unit or object of analysis should not be specific individuals suffering from kidney failure. The search for a transplantable donor organ and related struggles cannot be understood in atomistic-individualistic terms. The potential recipient rarely participates in the search, at least in most cases.

The familial, kinship and social relations that surround the ailing person plays the most vital role in the search, and therefore the challenge is collectively lived and negotiated. Negotiating kidney failure is a prolonged physically, emotionally and financially draining experience. Not only the ailing person gets decimated in the process, often the near-and-dear ones who initially participate proactively in supporting the ailing relative or friend through the crisis, gradually disappear from the scene. Time, money and physical expenditure are crucial factors for the ailing person as much as for the people immediately responsible for taking care.

This realization emanates not so much from pre-conceptions but from direct exposure to the field and the set of experiences intrinsic to it. Even if someone is not ethico-politically inclined to prioritize social relations around the ailing person, viz-a-viz the ailing person himself or herself, the medical-ethical barriers puts the ailing person at an objective distance from the outsiders, making it difficult for the researcher to explore experiences of the ailing person through corporeal proximity. People who have undergone organ transplantation are immunesuppressed[4], and are required to quarantine themselves from others and isolate. This clinical-physical barrier renders it impossible to conceive of the ailing person as an autonomous subject of experience.

Related to the first is the question of authenticity of voices. One of the possible ways of engaging experiences of people relating to any context is to presume a certain authenticity of voices of people associated with that context. This is generally derived from the assumption that the particular set of experiences being talked about are structured in such a manner that people exposed to those experiences or living those experiences in their everyday lives will narrate them in a particular manner, thereby imparting certain authenticity to the narrative itself. But one needs to be aware of the fact that not all that is uttered is an authentic representation of what the reality is – unuttered absences and erasures constitutes the weave of the narrative as much as uttered presences and (re)iterations do. Analysis therefore has to track the authentic through an idea of beyond. This confronts us with the third aspect which relates to the question of opacity of subjectivities, viz-a-viz transparency, that constitute the narratives of ethnographic engagement. Recognizing the opacity of subjectivities complicates the conception of ethnographic analysis as a gesture of seeking clarity. When the recognition of opacity of subjectivities confronts the desire for authenticity, ethnographic research as a process is rendered rife with multiple, unexpected contestations and tentative attempts at resolution.

Doing ethnography presumes a notion of travel to a particular locale or milieu (Clifford 1996). This has been the concept of anthropological research as a colonial practice. The opposition between sociology and anthropology is premised precisely on this categorical distinction. While sociology is conceived as the study of one's own society, anthropology is the study of other societies – involving journey to other unknown social worlds (Beteille, 2002). The concept of travel is therefore inherent to anthropology, both as research method and as a gesture of knowing the unknown social worlds. Such travel reaffirms or dismantles conceptions of what it means to be human in one's own or a particular society viz-a-viz another. While there is no doubt that any kind of anthropological journey, be it to another society or to the unknown recesses of one's own society, culminates in multiple possibilities of reimagining of self and society of anthropologist. The celebration of travel points to the assumption of mobility as lynchpin of anthropological method. The general assumption that the anthropologist has to constantly move or be mobile in order to track the complex nuances of the field is too taken-for-granted an assumption. Sometimes, as it proved to be the case in my study, it is necessary to station oneself as an ethnographer at a particular site. Such stationing, however limited or unimpressive, is crucial in the process of gaining knowledge. When both the observer and the observed are in constant movement, across a space with huge spread and a shifting public, many nuances are bound to escape the observer. Stationing helps locate recurrences of action over a particular spatial-physical area within a chosen temporal frame, as much as it helps locating unique actions and unexpected interventions.

Notes

1. The full form of S.S.K.M. Hospital is Seth Sukhlal Karnani Memorial Hospital. Presently it is known as Institute of Post-Graduate Medical Education.

2. A long rectangular piece of cotton cloth locally worn by men below the waist to cover the lower part of the body.
3. A locality in a district adjoining the city of Kolkata.
4. Immunesuppression is a routine biomedical procedure in organ transplantation where internal immune system of the body is lessened so that the foreign organ is accepted in the recipient body.

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