



Review Article

The Case of Doctor-Patient Relationship in Bangladesh: An Application of Relational Model of Autonomy

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Abstract : The objective of this article is to establish an alternative doctor-patient relationship model and describe its importance in the case of the doctor-patient relationship in Bangladesh. There is a lot of diversity in the religious beliefs, social norms and values in Bangladesh. Likewise, the development of biological science as well as medical technology, the allocation of healthcare resources must be considered as an important issue. That is why the autonomy of both doctor and patient is a relational factor here. Besides, the four traditional doctor-patient relationship models offered by Ezekiel J. Emanuel and Linda L. Emanuel are not beyond criticism. So, we need an ideal doctor-patient relationship model for Bangladesh to protect every patient's autonomy which will give freedom to the patient in choosing their own treatment as well as which will not conflict with the patient's social or cultural values. In this article, I have selected the relational model of autonomy as the method of alternative doctor-patient relationship model. Hopefully, this alternative model will work better since it considers care first concerning a patient's autonomy. Besides, doctors would treat their patients as a 'care seeker' rather than 'client' or 'customer', and simultaneously, patients would perceive their physicians as 'caregivers'. But, applying the relational model of autonomy in the case of doctor-patient relationship is more challenging in Bangladesh due to some obstacles like large numbers of population, illiteracy, insufficiency of skilled doctors and hospitals, corruption in medical sectors, social prejudices and so on. But, if we can overcome these problems, the relational model of autonomy will be considered as a suitable doctor-patient relationship model in Bangladesh.

Key words: Care ethics, doctor-patient relationship, relational autonomy, religious and social values, medical ethics, Bangladesh.

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Introduction: The doctor-patient relationship is an important issue in medical ethics. Since ancient times, all medical codes and

guidelines were concerned to identify the basic principles of an ideal doctor-patient relationship. But there is no Ideal model

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that is applicable to all cultures and all societies. The development of biological as well as medical sciences, medical technology, moral thinking, and social values, should be taken into consideration when we analyze any such relationship. In the last century, scholars have proposed various models for the doctor-patient relationship. The most accepted model is offered by Ezekiel J. Emanuel and Linda L. Emanuel. They mentioned four models of doctor-patient relationship in their article "Four Models of the Physician-Patient Relationship"¹.

According to Emanuel and Emanuel, these four models are: i. The Paternalistic Model, ii. The Informative Model, iii. The Interpretive Model and iv. The Deliberative Model. Emanuel and Emanuel's views are accepted and used in western well-ordered societies or developed countries². But, these models are not suitable for all countries of the world due to social, cultural, religious and economic differences. All of these models, any single model is not appropriate for the Bangladeshi context. Paternalistic model exists in our practices of medical ethics² though it has some merits too during emergency treatment¹. But, we reject it because this model violates the patient's freedom, respect as well as autonomy. We can consider informed consent as a better model than paternalism. But it is not applicable because of the number of illiterate patients, insufficiency of trained doctors. Besides, in the interpretive model, the relationship of doctor-patient is maintained in a value hierarchy which contains two rival agents: superior and inferior. In that model, a doctor has got a superior position where the patient is treated as inferior. Thus, we consider the interpretive model as inappropriate for Bangladesh. Finally, the deliberative model is also inappropriate because this model would not be compatible with the socio-economic and cultural pattern of Bangladesh. Therefore, we need an alternative practice of medical ethics in Bangladesh that will be suitable for our society and culture. As Bangladesh has a large population with different cultures and beliefs, it is difficult to ensure every patient's autonomy. The conception of autonomy in Bangladeshi people's beliefs and culture is relational. So, I argue for a richer conception of autonomy, especially 'Relational Autonomy' for the practices of medical ethics in Bangladesh. The

next section will introduce us to relational autonomy shortly.

Relational Autonomy: Relational accounts of autonomy have been substantially developed by feminist philosophers. This conception comes from the idea of care ethics where the caring issue is regarded as more important in medical ethics as well as in bioethics. To give a clear notion about relational autonomy, we need to know the characteristics of care ethics.

The care ethics esteems 'care' as the prime basis of morality and rejects the thought of 'fairness' in moral thinking. Care ethicists feature some human characteristics, for example, care, sympathy, empathy, compassion, relations, which are more familiar with the feminine gender. The care ethics begins from the feminist approach of morality. Carol Gilligan first worked on the development of care ethics in her book *In a Different Voice* (1982). Later, this conception of care ethics is expanded by some other feminist philosophers like Nel Noddings and Van den Hoven. Gilligan's works give us a positive interpretation by reconstructing the traditional negative understanding of care related to women and acknowledge care as an ethically important thought. In Gilligan's view, women are more caring to maintain relationships whereas men are concerned about "moral rules and justice"³.

The term 'relational autonomy' does not refer to a single synthesized conception of autonomy but is rather an umbrella term, designating a range of related viewpoints⁴. It refers to an idea of autonomy grounded on the social nature of people's lives. From these perspectives, people are intrinsically connected with a social environment marked by economics, politics, ethnicity, gender, culture, and so on. Besides, their profile is framed and formed by their social environment, just as their experience of embodiment, associations with others, and opportunities for a decent life.

The supporters of 'relational autonomy' specifically have contended that people's identities, needs, interests, and indeed autonomy are in every case additionally molded by their relations to other people. Not independence, but interdependence, is the

core of the relational idea of autonomy. Social environmental factors and connections enable us to flourish and develop a robust capacity for self-determination and identity formation⁵. Relational autonomy can be considered as a conception of autonomy that puts the person in a socially inserted organization of others. Relationships (with family, community and society), responsibility, care and interdependence are the key components of relational autonomy. Individuals build up their self-appreciation and form capacities and life plans through the connections they develop on a day and long-term basis. Therefore, relational autonomy states that social surroundings and relationships are essential for developing autonomy, and encourages us to act in manners guided by an ethic of trust and care⁶.

In medical ethics, the relational model of autonomy is the most popular model to protect a patient's autonomy nowadays. In health care, respect for autonomy emphasizes in particular the patient's freedom of choice, specifically over what happens to his/her body. In medical issues, all patients are fundamentally connected with a social environment marked by economics, religion, politics, ethnicity, gender, culture, and so on. That is why every patient's autonomy is different. So, a Patient's autonomy can be protected by applying relational model of autonomy in the case of medical ethics such as patient-centered care, doctor-patient relationship and so on.

Suitability of Relational Autonomy in Doctor-Patient Relationship in Bangladesh:

There are so many reasons why the relational model of autonomy is suitable for a developing country like Bangladesh. I will figure out some reasons and argue that relational autonomy is more suitable than any other doctor-patient relationship model. Some reasons are given below:

Bangladesh is a poor country with a huge population. The financial position of each person is different. Everyone's type of autonomy is not the same. People of different levels of society have different sorts of autonomy. If we give the same medical care to everyone, then it will not be able to protect everyone's autonomy. The autonomy of

people of the upper level of the society is not applicable to the lower level people of the society. Many people are involved in many issues such as individual belief, ritual, religion, culture, etc. in the field of autonomy. The doctors of our country do not treat all patients in the same way. The attitude of doctors is paternalistic. This paternalistic behavior of doctors is most commonly seen in the treatment of poor patients. Relational models of autonomy can be shown in different ways to treat all patients from different economic classes and protect everyone's autonomy.

Constraint Factors: Religious Belief and Social Values:

An important aspect of Bangladesh is that people of different religions live here. Most of the population is Muslim (88%) while a considerable number of citizens are Hindus (10%), Christians (1%), and Buddhists (1%). Here also live various ethnic entities and those who have different cultures and beliefs. Every person from every religion has different rituals and beliefs. In medical treatment, doctors should consider that. If the treatment policy contradicts the patient's religious beliefs, that will violate the patient's autonomy. Some cases like abortion, organ transportation, receiving blood from others and so on may create some critical conditions.

For instance, one of the most popular cases in Bangladesh is the abortion case. Although abortion is legally prohibited in Bangladesh, abortion may be justified if there is a risk of death for the newborn and the pregnant mother. Besides, most Muslims does not support abortion because of their belief. Conservative Muslims never support abortion because it is prohibited in Islam. According to Islam, every life is sacred and as a fetus is a living entity, we have no right to kill a fetus and ruin its sanctity. But in recent times some liberal Muslims support abortion. Islam has a different view of the life of a pregnant woman is threatened. For example, if a woman is at risk of cancer or any other incurable disease due to pregnancy, or if there is a risk of death in childbirth, and if the matter is directed by a neutral and experienced doctor, then abortion before the age of four months is legal according to Islam⁷. Conversely, sometimes abortion becomes urgent to save the mother's life but the Muslim mother does not want it as she believes her religion. In that situation,

abortion will not be supported. So, in these cases, doctors should know the patient's opinion to support the patient's freedom as well as to protect the patient's autonomy. Sometimes, many Muslim families do not support abortion but the woman who is pregnant supports it. So, in this case, the woman's opinion should get priority.

Now let us come to the context of Hindus. Traditional religions have different beliefs about abortion, rules and regulations that Hindus follow. Abortion is not supported in any way in the traditional Hindu scriptures. According to the Hindu religion, killing a fetus through abortion is equivalent to killing a priest. Even a woman who kills a fetus through abortion seems to destroy her offspring⁸. That is, in Hindu religious culture, abortion has been identified as an extremely reprehensible act. The *Rigveda* says, "Vishnu himself is the guardian of the future newborn" (*Rigveda* 6, 36: 9). That is, Vishnu himself has taken the responsibility for the life and death of the fetus. In that case, killing the fetus during pregnancy would be a great sin. Again, in the *Shatapatha Brahmana*, it is said, "The woman who has removed the fetus from her body has undoubtedly committed a great sin" (*Shatapatha Brahmana* 3: 1.2.2.1). An analysis of these scriptural statements shows that abortion is not supported in any way in the traditional Hindu scriptures. Liberal Hindu scholars, however, support abortion in the interest of saving the lives of pregnant mothers and newborns.

Christianity also opposes abortion. To Christians, human life is sacred and a gift from God that is said to be respected and protected. This teaching is called the holiness of life. The Bible teaches that man was created in the image of God and also teaches that killing is forbidden. Jesus reminded his followers that every living thing is precious to God. Considering that, the killing of fetuses is also prohibited. In the case of a woman's pregnancy, the first fetal performance according to Christianity is a time when the mother feels the movement of the first fetus. According to ancient Catholic theology, the soul is received during the first fetus. According to Christian doctrine, the 'soul' is a boundary that separates non-human beings from human beings⁹. So it is wrong to kill an embryo in the womb. However, some liberal Christian theologians believe that abortion can

be supported if the pregnant mother and child are at risk of death. Thus, there are differences of opinion among Christians regarding abortion, which also applies to the Christian citizens of Bangladesh.

The moral problem of abortion is also created in Buddhism. Buddhism does not support 'killing living beings' like abortion. Buddhists believe that no life should be neglected or deliberately killed. Buddhism does not support abortion because life is deliberately killed here. However, there is a crisis in Buddhism when pregnant mothers and children are at risk of death. Because, if abortion is to be accomplished to save a pregnant woman, it will conflict with Buddhism. Therefore, in such a crisis, different decisions may have to be taken.

Another topic that is currently being discussed in the medical field of Bangladesh is organ transplantation which involves social and religious issues also. For example, most Muslims believe that Islam forbids organ donation. Muslims who oppose organ donation believe that since the *Qur'an* does not directly mention organ donation, organ donation is not acceptable in Islam. According to Islamic custom, the body of a dead person is to be buried as soon as possible after death. Therefore, the preservation of organs from the body of a dead person cannot be supported. Liberal Islamic thinkers, however, advocate saving lives through organ transplants because protecting human life is a virtuous act in Islam.

Likewise, organ transplantation is supported in Hinduism. Organ donation is supported in Hindu scriptures because it saves the life of another human being and simultaneously, selfless donations (*Daan*) are considered as a pious act. In Hinduism, charity is the third of the ten virtuous deeds. Besides, the death afterlife is an ongoing process of rebirth in Hindu belief. This concept is seen as a positive reflection in organ donation and transplantation¹⁰.

The main branches of Christianity, both Catholic and Protestant, support and encourage transplantation. Christians consider organ donation to be an act of love and a way to follow Jesus' example¹¹. Again, organ donation and transplantation are not supported in Buddhism. According to Buddhist culture,

corpses have to be kept intact with respect to nature and ancestors. Therefore, it is not justifiable to remove an organ from the body of a dead person before cremation after death¹².

There are some additional cases like some Buddhists deny taking vaccines for bacterial diseases. Because they believe that germs are also living entities and according to their religious belief, killing a living entity is a sin. They give priority to the other living entity rather than their own life. In these cases, heavenly salvation is more important than saving one's own life. So, the doctor should keep this in mind when he gives treatment to a Buddhist patient.

Some gender-related issues are also involved in the medical policy of Bangladesh. There are many differences in diseases between men and women, and their treatment is different. But, in a male-dominated society like Bangladesh, it is not considered properly. Most of the time, our society does not require the necessary attention to women, especially pregnant women. An adult girl needs special care and nutrition during her period. But, because of some prejudices, most of the time we are not concerned. In our society, after the marriage of a girl, she has to live with her husband, accommodating the new culture and ritual of her father in law's house. So, in Bangladesh, girls are facing many obstacles where the men do not have to go through such problems. For that reason, the autonomy of man and woman is not the same in Bangladesh and the medical treatment is not the same, rather relational. In doctor-patient relationships, these sorts of gender-related issues should be considered. That is why relational autonomy is important to protect men's and women's different autonomy.

From that discussion, we understand that in the case of doctor-patient relationship in Bangladesh, considering every patient's religious beliefs and social issues are very important. Because, in maximum cases, the patient's value and the doctor's value may not be the same. Doctor value may be saving a patient's life; conversely, a patient's value may be heavenly salvation following his/her own religious or cultural beliefs. Doctors have no right to hit a patient's belief and social value. Everything is a related issue in treatment. When a patient's religious beliefs and social values are considered, then the

patient's autonomy will be protected. Thus, we may claim that relational models of autonomy can play a vital role in Bangladesh content.

Constraint Factors: Patient's Economic and Geographical Differences: Bangladesh is a very poor country and People are engaged in different occupations. All classes of people including the rich, middle class, and poor people are here. So it is not possible to afford the treatment costs of all people equally. So, everyone's autonomy is not the same here. For example, in the case of high-cost medical treatment, rich or middle-class patients can sustain it but poor patients cannot. Sometimes, for the poor patient, running the family cost is more important than their medical treatment. In such cases, doctors should inform patients about their treatment costs. Also, there are differences between the physical condition and treatment of urban people and rural people. The eating habits of people in all the districts of our country are not the same. There is also a difference between the food and nutrition of the people of the different regions. In those districts where natural disasters are high, people of these areas suffer from malnutrition and diseases. It is especially seen in the northern districts of Bangladesh. Most of the northern districts of Bangladesh are poor and the children are deprived of necessary vaccinations after birth. Most of the children in the village grow up in an unsavory environment. So, the medical services of the people of the city will not be the same as the medical services of those rural area people. Here, geo-cultural identity is an important part that must be considered in medical policy. Considering the geographical, economic and environmental aspects of different people in each region of Bangladesh, healthcare will be equally balanced. So, we may say that economic and geographical issues should be considered as a relational issue in medical policy like doctor-patient relationship in Bangladesh. Here, the relational model of autonomy can ensure the autonomy of people by treating people in one area with their medical needs.

The Benefits of Relational Autonomy in Doctor-Patient Relationship: When we get benefits from the applications of relational

autonomy, then we will realize why the Relational model of Autonomy is so important for Bangladesh in the context of doctor-patient relationship. Now, this section will emphasize the benefits of relational autonomy. The benefits that will be the most in doctor-patient relationship in Bangladesh are given below:

Firstly, the paternalistic approach will be reduced. The patients will get the freedom to express their own opinion about diseases and the doctors cannot impose any treatment on the patients. Therefore, the patient will be informed about their medical treatment and hence the patient's autonomy will be protected.

Secondly, a patient's religious beliefs and social values are not violated. In the relational model of autonomy, a particular patient's religious beliefs and social values are considered by the doctor. Thirdly, there will be no class discrimination between doctor and patient where paternalistic model builds class discrimination between doctor and patient creating superior position for the doctor and treats the patient as inferior. In the paternalistic model, patients are dominated by the doctor whence in relational model of autonomy, patients get proper freedom.

Fourthly, there will be a strong relationship constructed between the doctor and the patient. In relational model of autonomy, patients are informed about their own diseases. For this reason, patients get an idea about their diseases and treatment. Hence, the patient gets the confidence of the doctor's advice. Because, next time, the patients will be more careful about their health and diseases. Consequently, this built up a positive relationship between doctor and patient.

Fifthly, the apprehensiveness of the patient may get relieved and the confidence will be reached. Patients will be psychologically strong when they will be informed about their health condition and get the freedom to choose their own treatment which is suitable.

Sixthly, corruption in medical treatment will be reduced. Corruption in the medical field is a common instance in Bangladesh. Paternalistic approach cannot remove this corruption because patients are treated here as a client or a customer. But, the relational model of autonomy will consider all patients as a care seeker and make the doctor a caregiver. As a

result, care ethics will be established instead of professional attitudes and there will be no corruption here. Eventually, People in Bangladesh will rely on the medical services of the country. Because maximum people have no reliance on the treatment policy of Bangladesh. Paternalistic approach is one of the reasons for this attitude. Thereby, people go to inexperienced doctors and take the wrong treatment. Relational model of autonomy can increase the reliance on Bangladeshi medical treatment policy.

Challenges of Applying Relational Autonomy: When we apply the relational model of autonomy in the case of doctor-patient relationship in Bangladesh, it will be very challenging. We have to face many types of obstacles. This section will focus on the challenges of applying relational autonomy.

Firstly, Population is the first major obstacle. Bangladesh is a small country with a large number of populations. According to the report of Bangladesh Statistics 2019, there are 85,633 registered physicians, 8,130 registered dental surgeons and 48,001 registered diploma nurses in Bangladesh for the whole population of 164.6 Million¹³. As indicated by these statistics on physicians who were registered with BMDC (Bangladesh Medical and Dental Council), there is only one physician per 1,847 people¹⁴. Necessarily, these data show a very poor doctor-patient ratio and have a significant impact on the doctor-patient relationship. For this reason, the doctor-patient relationship is rather complex in Bangladesh because doctors claim that it is not possible to maintain an ideal relationship with patients since they have to provide services for a gigantic populace inside a restricted period. Managing an excessive number of patients and the pervasiveness of conflict of interest have serious negative outcomes. In some cases, one can even doubt whether a doctor-patient relationship is actually present in treatment decisions. Now, the question may be raised about where the patient does not receive medical treatment properly, and then how we can protect everyone's autonomy.

Secondly, illiteracy plays as a major obstacle in establishing relational autonomy. Most of the people of our country are illiterate and they

have no idea about medical treatment. Thus, discussing about their diseases and treatments is quite impossible. At the same time, each patient should be aware of their respective religious beliefs and social values which they will share with the doctors. In most cases, many patients are not aware of their own religion. In these cases, the guardians of patients assist in giving informed consent. But, this process does not establish the patient's own autonomy and this may turn into another form of paternalism. If the patient is illiterate, communication between the doctor and the patient is interrupted and the doctor is obliged to provide medical care which s/he thinks better. So, in this case, autonomy will not be established, and as a result, it will turn into paternalism. So, the main factor is that if we establish relational autonomy in doctor-patient relationships to ensure every patient's autonomy, everyone must be educated at least.

Thirdly, language is an important medium to establish relational autonomy successfully in doctor-patient relationships. If the doctor and the patient do not understand each other's language, then proper communication between them is not possible. Doctors have to study in English and the language of medical science is very complex which patients cannot understand properly. The doctor also needs to understand the language that the patient will speak. As most of the people of Bangladesh are illiterate, the lack of proper use of language will be a big obstacle in establishing relational autonomy. The people of most districts of Bangladesh speak regional languages and they name various diseases in regional terms that may be unknown to the doctor. As a result, the doctors will not comprehend the patient's religious and social values properly and the kind of medical care they provide to the patient may not be properly reported to the patient. Then the patient's autonomy in the medical service will not be established securely. So, in these types of cases, doctors should know the use of people's language in different regions. Then relational autonomy will only get success.

Fourthly, doctors should be highly educated and have to be experts on various diseases. The skilled and specialist doctors who are in Bangladesh are mainly providing medical services to the capital Dhaka and divisional cities. In rural areas, there are few experts

and skilled doctors. There are also many quack and fake doctors in the country. So people of all classes will not get equal treatment when they go to different classes of doctors. Besides, if the doctors want to understand the religious and social values of their patients, then they will have to study it. In addition to medical science, doctors should keep in mind the notion of different branches of knowledge like history, religion, anthropology, social science and so on. But sometimes the doctors do not have the proper skills in these areas. Therefore, to ensure patient's autonomy, the doctor has to be proficient in his own field.

Fifthly, another major obstacle is the insufficiency of the allocation of healthcare resources. The allocation of healthcare resources includes distributing health-related materials and services among various uses and people. The medical resources that are used in the Dhaka city hospital are not available in the hospitals of other districts outside Dhaka. As a result, discrimination creates in providing services to patients in different areas of hospitals. Consequently, both medical treatment and the autonomy of the patient are hampered. So, ensuring the allocation of healthcare resources in every hospital in Bangladesh is very important to establish relational autonomy in doctor-patient relationships in Bangladesh.

Sixthly, in emergencies when the patients are about to die or in a coma, this is impossible to get information about the patient. In these situations, a patient's life is more important than protecting the patient's autonomy to the doctors. For example, there are many road accidents that occur in Bangladesh every day where the identity of the victims is unknown. In this situation, doctors should give priority to protect patient's lives. Here, the doctor's value is protecting the patient's life and the doctor will decide what sort of treatment will be best for the emergency patients. In this case, paternalism is more acceptable than relational autonomy. So, we have to keep these points in mind.

Seventhly, the doctor's role in Bangladesh is multidimensional. A senior doctor simultaneously is an instructor in clinical school and a chief of the hospital as well as a private consultant. Most of the doctors work as a clinical officer and private practitioner.

Besides, doctors work in diagnostic centers or get commissions from them, subsequently, they have contending interests. Obliquely, Doctors help pharmaceutical companies to market their medicine prescribing their medicine to the patients and get some percentage of the expense from the companies^{15,16}. These types of issues impact the patient-physician relationship and this indiscipline in the medical sector will also create problems to establish relational autonomy.

Above the discussion, we found that a lot of obstacles will be faced to establish relational autonomy in the case of doctor- patient relationship in Bangladesh. It is a very challenging issue. But, with a view to accepting these challenges, we need to develop some issues to tackle these obstacles. The steps that will be taken in this regard are discussed below:

First of all, we need to give proper training to the doctors and the number of doctors has to be increased. The huge population may seem to be a big obstacle to us but this will not be a big obstacle for us if we can make adequate skilled and specialist doctors. In implementing this, the government will have to increase the budget in the medical sector. At the same time, adequate hospitals and health complexes should be built in the city and village areas. Besides, the allocation of healthcare resources should be ensured in every hospital.

In Bangladesh, the rate of education should be increased and everyone must have correct ideas about their social and religious values. At the same time, the doctors also have the correct ideas about the religious and social issues of the people living in Bangladesh. Besides, the government will have to pay attention to the corruption in the medical field. The relational model of autonomy in doctor-patient relationships will never be established unless corruption is suppressed in the medical sectors. Because, if the relational model of autonomy is established and simultaneously, the medical sector is corrupted, the medical policy will be paternalistic again.

Conclusion: This article shows how to reduce paternalistic approach in the medical sector in Bangladesh and build up an appropriate

doctor-patient relationship model that may protect every patient's autonomy considering all religious, cultural, economic and geographical circumstances. This alternative model will give freedom to the patient in choosing their own treatment as well as which will not conflict with the patient's social or cultural values. For this purpose, I have used the relational model of autonomy in this article as a suitable model in the case of doctor-patient relationship. In this regard, I have discussed different religious, social, cultural values which exist in the belief of people living in Bangladesh. Most of the people in our country are Muslims. We found that various medical issues such as abortion, organ transplantation etc. exist here. Sometimes, Islamic religious values contradict medical policy. The same happens to Hindus, Christians and Buddhists. If a doctor's values contradict a patient's social or cultural values, the patient's autonomy will be violated. Because, sometimes a patient's heavenly salvation is more important while for a doctor, saving a patient's life is more important. As we found that relational autonomy considers a patient's cultural and social value, it is more appropriate for Bangladesh in the case of doctor-patient relationship. But, applying relational model in doctor-patient relationship is more challenging in Bangladesh due to some obstacles like large numbers of population, illiteracy, insufficiency of skilled doctors and hospitals, corruption in medical sectors, social prejudices and so on. But, if we can overcome these problems, relational model of autonomy will be considered as a suitable doctor-patient relationship model in Bangladesh.

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