At the turn of the century, a middle-class discourse of domesticity was certainly ubiquitous in Cairo, propagated through competing ideologies, including nationalism, but consistently made by the privileged classes of Egypt. Particularly among the Egyptian secular nationalists, there were doctors who gave this brand of nationalist discourse an added level of legitimacy and credibility, through a new-found authority brought by the rising importance of modern medicine. The British colonial encounter was certainly pivotal in creating this new-found medical authority, indeed in forging a new template of the ‘modern Egyptian doctor’.

This article is part of a larger study, and attempts to analyse the contingent historical processes that explain: (a) the new-found prominence and socio-political authority of the ‘modern Egyptian doctor’ who became almost exclusively male, urban, upper-class and English speaking, at the expense of the Egyptian midwife; (b) the role that the Egyptian medical establishment and its authority played in reconstituting the ‘modern Egyptian woman’ in nationalist terms; and lastly, (c) how these two formations left in their wake a popular discourse that not only medically explained woman’s roles and rationalised the domicile, but also ‘scientised’ Egyptian culture.¹ At the heart of this study, then, is the question of how Egyptian women, presented here as both medical subjects (e.g. midwives), and medicalised objects (e.g. housewives), were implicated by the intersecting historical processes of colonisation, modernisation and nationalism – an intersection that also explains the ‘scientisation’ of Egyptian culture.

On the topic of colonial encounters, Egypt has certainly been a long-standing, privileged field of study, especially when related to changes in education.² To discuss turn-of-the-century Egypt in terms of the emerging
cultural and social practices brought by the colonial encounter is not a novel idea; most noteworthy is Timothy Mitchell’s *Colonising Egypt*.3 Gender historians such as Leila Ahmed, Margot Badran and Beth Baron, have gone further to show how Egyptian women and gender relations more specifically were affected by Egyptian nationalism, inspired by Britain’s colonial presence.4 In fact, Egypt as a field of study has led the way in scholarly discussions about the inextricable ties between woman and nationalism in Middle Eastern and North African societies under colonial rule, from which other scholars have taken their cues in writing their own historical narratives.

The otherwise unrecognised role that medicine played in the cultural changes brought by British colonialism and Egyptian nationalism is missing from this scholarly wisdom. Put simply, historical narratives have traditionally paid much attention to the various ways in which Egypt entered the modern (read: Western) ‘rational’ world through its integration into the capitalist world system and their indelible effects. Little has been written about the ways in which the imperial spread of modern medicine, what David Arnold calls ‘colonial medicine’, facilitated this integration. Indeed, the historical process of medical modernisation under colonial supervision that accompanied Egypt’s economic transformation ultimately yielded a different rationale for organising gender relations, and thus Egyptian society. It is this powerful social re-organisation, or rather re-invigoratation of traditional gender roles justified by modern medicine, which underpins the expression, the ‘scientisation’ of culture. This article, then, attempts to uncover the medical rationale for turn-of-the-century Egyptian gender norms, as a way of understanding how gender identity and relations were impacted by capitalist transformations, most visibly characterised by shifts in consumption patterns, a growing urbanity, and by implication, notions of social space, but also and concomitantly, by the professionalisation of the medical establishment.

Isolating medicine as the primary analytical construct to explain historical changes in modern society is not entirely new to scholarship on the Middle East and North Africa in general and Egypt specifically. Increasingly, studies on the intersection of imperialist politics, modern medicine and gender have been on the upswing, particularly on Morocco, Tunisia, Palestine and Iran.5 It is Egypt, however, that has blazed the trail, with such distinguished scholars as Laverne Kuhnke, Amira Sonbol, Nancy Gallagher, Khaled Fahmy and the French historians, Serge Jagailloux and Sylvia Chiffoleau, seeking early on to understand the politicised place of Egyptian medicine in modern state building.6 This scholarship converges in one critical argument: the role of modern medicine in legitimating and being legitimated by state policies, or put simply, the contingency of medicine and politics. In sum, at the turn of the century, increasingly in

the Middle East and North Africa as elsewhere, modern science became the officious rationale of culture. By adding gender to this matrix of state building and colonial medicine, we see more clearly how culture was ‘scienticised’ not only in modern medical terms, but gendered ones as well.

The British took over Cairo’s only school of medicine and its adjoining hospital, called Qasr al-Aini, in 1893, over a decade after occupying Egypt in 1882. It was not until 1929 that Qasr al-Aini was returned to Egyptian control. During this short, but intensely active, period in Egyptian medical history, certain colonial reforms were instituted that ultimately determined and changed the composition of which Egyptians became doctors, as well as what kind of medicine they practised. That is, colonial reform, based on a philosophy of Anglicisation, helped forge a template of the ‘modern Egyptian doctor’ whose authority was based on what became modern medical knowledge.

Anglicisation here refers to an institutional process of medical professionalisation brought by colonial reform, the most critical of which was the institutionalisation of clinical medicine. This term does not suggest a cultural transformation of Egyptian doctors by engendering a Victorian outlook toward medicine or the medical profession. Rather, Anglicisation was structural in the way that it targeted the reform of Egyptian medical institutions, following a London-based model. This model was mapped out by Sir E. Cooper Perry, the Superintendent of Guy’s Hospital in London, who was commissioned by the colonial regime to reorganise Qasr al-Aini. His report, often called Perry’s Gospel, was essentially the basis on which the constitution of the medical school and hospital was built until 1927, when Qasr al-Aini became an academic institution and was decreed the medical college of the Egyptian University (later Cairo University). The year 1927, however, did not end Perry’s influence in medical affairs; he was commissioned yet again to write a report on how to convert Qasr al-Aini into a university faculty. Neither report, in short, should be underestimated in shaping colonial medicine in Egypt.

Establishing a clinically dominant medical curriculum was part of a larger goal of medical professionalisation – a vision established by the Perry Report. Modern clinical medicine, however, was not new to Egypt. In fact, the British colonial encounter was not the first time that Egypt was medically modernised according to a western model. At the turn of the century, under the Ottoman viceroy Muhammad Ali (1805–1848), Qasr al-Aini underwent extensive modernising changes under its French director, Antoine Bertelemy Clot (1827–1849), known as Clot Bey, who was brought from Marseilles to organise Egypt’s medical system. While there is some scholarly debate about the motives of Muhammad Ali’s state building policies, what is undoubtedly clear is that his autocratic
style of rule did not prevent him from borrowing from Western, and particularly French, modernising models. Notwithstanding Clot’s French imperialist view of Egypt, the goal of his supervised reforms was not to ‘Frenchify’ Egyptian medicine; rather, it was to import French medical knowledge and technologies in ways undistruptive to the Egyptian medical system, while also attempting to nationalise medical practice by putting preventative care in the hands of Qasr al-Aini trained doctors. In a word, Clot attempted to modernise Egypt’s medical system without necessarily westernising it. Accordingly, his reforms of appointing administrative positions within Qasr al-Aini, recruiting students, updating the medical curriculum, and relying on Arabic and French as parallel languages of instruction, are indicative of his larger method of modernising. Significant about Clot’s reforms, for the purposes of this paper, was that a culturally sensitive four-year medical curriculum based on clinical medicine, modelled on the one in force in France at the time. Clinical medicine, therefore, was not new to Egypt – it had its beginnings under an Egyptian ruler early in the nineteenth century.

What was different about the reinvigorated importance of clinical medicine at the turn-of-the-century in Anglo-Egypt was, quite simply, the context. First, Egypt was now under colonial rule and thus Qasr al-Aini’s reform was under the direct official supervision of, not the Ottoman descendant of Muhammad Ali, Khedives Tawfiq (1879–1892) and Abbas Hilmi II (1892–1914), but the British-appointed director, Dr Henry Pottinger Keatinge. Second and consequently, the institutionalisation of British-style clinical medicine at Qasr al-Aini differed in its content, since modern medicine was itself evolving in Europe over the course of the nineteenth and twentieth century; hence, clinical medicine was imported to colonies in its evolving form. Third and related, given Britain’s explicit imperialist policy in Egypt, the clinical medical curriculum imported to Egypt’s School of Medicine from London was now intended to Anglicise Egyptian medicine. Fourth and lastly, as in the early nineteenth-century, the goal of instituting a clinically based programme was to professionalise medical practice. The goal of professionalisation early in the twentieth century cannot be divorced from the rise of capitalist dictates that reconfigured the very nature of occupational work in Egypt during this period. A medical professional in the early nineteenth century did not have the same societal meaning, hence importance, as a medical professional at the turn of the century because of changes brought to modern medicine, but most specifically to medical professionalisation, by capitalist transformations. What this article argues is that once this elite group of Egyptian practitioners became self-conscious as an autonomous class of professionals in the 1920s, they were able to exercise a socio-political authority that rendered them invisible yet powerful social intermediaries between the state and society.
In order to understand how Anglicisation turned Egyptian doctors into modern professionals, a few of these reforms will be discussed, since they collectively constitute the making of colonial medicine in Egypt. In sum, the British administrative overhaul of Qasr al-Aini largely rendered medicine exclusive and specialised knowledge – knowledge that came to be monopolised by Qasr al-Aini doctors, the only licensed, thus legitimate, medical practitioners recognised by the colonial, and later the Egyptian, administration. The reality of colonial medicine, in other words, did not prevent Egyptian medical professionals from inheriting their own social agency, which needs to be explained.

Under the British Consul-General Lord Cromer (1883–1907), who feared ‘manufacturing demagogues’, Egypt’s educational system at large was made: (a) restrictive, due to new policies that guided entering and graduating from schools; (b) exclusive, since school fees were now instituted for the first time in Egypt’s modern history; and (c) an urban phenomenon, as many of the secondary and all three of the professional schools (e.g. the Schools of Law, Medicine and Engineering) were based in Cairo. In more general terms, this meant that fewer Egyptians went to school. Those who did were of the wealthier classes and most were concentrated in urban areas.¹⁰

Predictably, medical recruits were drawn from an already limited pool of Egyptian students, and because of strict application requirements and a rigorous medical programme, even fewer of these graduated successfully. The number of Qasr al-Aini graduates, for example, never exceeded fifty in any given year of the colonial period, and the average was twenty graduates per year at a time when Egypt’s population totalled at least nine million, beginning in the late 1890s.¹¹

These figures stand in marked contrast to the number of medical applicants during the independence era, when a process of Egyptianisation of schools and teaching staff took place on all levels and the appeal for professional study grew. By 1925, for instance, out of the 3,368 total university students at Cairo University, 544 were medical students, the third largest figure after law (1,319 students) and engineering (574 students).¹² In short, because medicine was able to attract a steady flow of medical students after Egyptian independence, the pre-independence figures demonstrate the strictness, and by implication exclusivity, of medical instruction during the colonial period.

No less significant in creating the ‘modern Egyptian doctor’ were the more focused Anglicising reforms after 1892, when the question of British withdrawal was resolved and Lord Cromer entrenched himself and British imperialism more resolutely within Egypt’s government administration. This imperialist commitment is best reflected in the quantity and quality of Qasr al-Aini positions as well as curriculum reform.
After 1892, Qasr al-Aini’s administration was run exclusively by Englishmen. Dr Keatinge, for instance, was its longest-standing director during the colonial period (e.g. 1893–1919) and put the greatest emphasis on Anglicisation. He assigned the highest faculty and administrative positions – now defined by a new medical cadre with their accompanying rank, rights, obligations and salary caps – to English physicians, many of whom were brought from London. Importantly, in the colonial medical grid, one’s rank was determined by the type of medicine one practised, the greatest levels of importance and authority being placed on the fields of clinical and surgical medicine.

In this new grid, the physician, followed by the surgeon, were the supreme medical authorities, since only they could medically isolate the source of an illness or identify the nature of an injury and treat it. Moreover, precisely because of the infused importance of these medical fields, the physician and surgeon were given added administrative authority by the Perry Report. They alone were in a position to judge on critical matters, such as hospital treatment and bed allocation. By contrast, Egyptian doctors were made ‘assistants’ – a rank assigned the lowest salary and barred from private practice – with very few exceptions. However, this changed during the First World War, when English doctors left Egypt to volunteer in the service, leaving Egyptian doctors to fill their administrative and medical positions.

To recapitulate, clinical medicine was not new to Egypt; the curriculum reforms undertaken by the colonial administration, however, were. Such reforms dealt mainly with introducing new or modified medical subjects (e.g. basic clinical medicine, bacteriology, operative surgery, gynaecology and forensic medicine), with the help of imported British medical texts. As English was made the only language of instruction in specialised schools, the problem of access was eventually resolved. Also significant was that outstanding Egyptian students were sent on medical missions to London, at their own expense, to pursue post-graduate study in medicine, most of whom chose clinical fields.

In summary, Anglicising reforms had the indelible effect of rendering Egyptian medicine the privilege of an elite corps of Egyptians who were male, upper class, urban and English-speaking. Specifically, reforms that more closely controlled the composition of the student body and revised the curriculum were particularly effective in transforming Egyptian medicine into colonial medicine; these two areas reconfigured who was allowed to practice medicine and what was practised, shaping the template of the ‘modern Egyptian doctor’.

The authority of this medical man was contingent on the state’s only medical school, as it alone awarded medical diplomas and conferred licences to practise. In addition to institutional authority, government
employment guaranteed and deepened Egyptian doctors’ investment in the fate and survival of the state apparatus. Indeed, it is this growing symbiotic relationship between modern medicine and the state that helps explain how Egyptian medical discourse became ensconced in nationalism. That Egyptian doctors were further made exclusive by their modern, specialised clinical knowledge solidified their authority, not simply as medical experts, but arguably as socio-political agents of the state. They, after all, spread state-sponsored modernisation through everyday medical practice in a society that desperately sought treatment and cures from the ‘deadly trinity’, namely cholera, the plague and smallpox.16

Thanks to the rising prominence of modern medicine in general, and the authority of a specific newly shaped science of woman (gynaecology and midwifery), it is not surprising that Egyptian women – as both midwives and housewives – were rendered subordinate to the Egyptian doctor’s exclusive authority. The integration of gynaecology into Qasr al-Aini’s clinically based medical programme necessitated the re-organisation of the School of Midwifery, which was centralised and institutionally subordinated to the School of Medicine, as directed by the Perry Report. The Anglicisation of the Medical School, in short, necessarily and concomitantly Anglicised the newly named School of Nurses and Midwives.

Accordingly, this process affected women’s positions in equally far-reaching ways as it did doctors’ positions, except that instead of being empowered, these female practitioners were disempowered by medical modernisation. Egyptian midwives, or hakimahs, had to institutionally relinquish their previous medical roles as independent practitioners, or ‘doctresses’, and defer to the Egyptian doctor. Before the colonial encounter, in addition to midwifery, these doctresses performed extra-midwifery functions, treating common ailments such as eye infections, scabies, syphilis and dislocated or broken limbs. They offered free consultations for all city inhabitants and provided emergency aid to victims of drowning or asphyxiation. They dressed injuries; gave free vaccinations, were dispatched to confinement cases, and verified and certified causes of deaths of women.17 For all intents and purposes, they functioned medically and socially as independent medical practitioners.

Colonial reforms, however, reconstituted the position of the hakimah so that her assigned medical roles were not simply subordinate to the doctor, but were premised on woman’s medically rationalised nature: nurturing, care-taking and maternal. The hakimah, once an independent doctress in Egyptian society, now became a dependent nurse on the model of those trained by Florence Nightingale and her successors. Moreover illiterate folk midwives, or dayas, were almost entirely displaced from the legitimate practice of modern midwifery (though, predictably, they continued to practise outside the medical establishment).
The institutional subordination of the hakimah is best illustrated by the use of forceps: only Egyptian doctors were medically, thus legally, allowed to use these gynaecological instruments since such births were deemed medically problematic and therefore necessitated a qualified expert. The nurse-midwife, not trained in clinical medicine to the same degree as Qasr al-Aini doctors, only delivered babies in ‘normal’ births, thus was not medically authorised to use forceps, nor were dayas. However, because of Egypt’s explosive population growth and the paucity of medical practitioners, concessions were made by the state so that dayas could birth ‘normal’ deliveries in the rural areas, but only on the condition that they underwent a crash-course taught by hakimahs in modern midwifery and become semi-certified, despite their illiteracy. Despite this the certified daya barely ranked on the modified hierarchy of modern medical professionals. Thus, as midwifery institutionally deferred to gynaecology, an intended process of medical professionalisation at Qasr al-Aini ultimately yielded the masculinisation of Egyptian female medicine. 

Ironically, despite her subordinate position, the midwife was arguably a more important contributor to state-sponsored medicine than doctors. In fact, figures show that midwives out-delivered doctors. More Egyptian births were delivered either in the mother’s home or in the wards of the Maternity School by trained dayas and nurse-midwives than were delivered by Qasr al-Aini doctors. The number of midwife-attended births was 4,419, of which 182 were ‘abnormal’ births (e.g. triplets, caesarian sections and craniotomies, in which doctors assisted), and the total number of registered visits made to patients in their homes was 40,660. By 1927, the total number of gynaecological and midwifery outpatients was 67,135. In 1922, by contrast, there were a total of 367 obstetric in-patients, sixty-seven of whom were pregnant women under observation. By 1927, the total number of gynaecology and midwifery in-patients was 924. In summary, the majority of Egypt’s population, concentrated mainly in the rural areas, preferred to give birth at home or in state clinics with the assistance of professional midwives, rather than doctors in hospitals.

Despite the central role of midwives as state agents, it was the doctors who reaped greater benefits from their knowledge of female medicine, but not by delivering normal-birth babies. Rather, they derived their exclusivity from their ability to medically resolve women’s bodily problems, such as abnormal births or gynaecological diseases or problems, through medically-sanctioned interventions, particularly surgery. The numbers of surgical operations increased markedly between 1910 and 1930 and the surgeon became a more prestigious, respected professional in Egypt. Of this elite group, gynaecological surgeons certainly reaped much of these benefits, given that the number of gynaecological operations also rose significantly during this period. By 1927, for instance, 924 gynaecological operations were performed.
and midwifery in-patients were admitted to the hospital section – a substantial increase compared to a decade earlier, when the total was 142.\textsuperscript{20} Of these, 924 in-patients, 401 (43 per cent) required either gynaecological or midwifery operations. Indeed, the expertise of the surgeon was clearly in demand, and gynaecology found its highest medical authority in the hands – figuratively and literally – of the male doctor.

Just as the process of professionalisation reconstituted the ontological category of the Egyptian midwife, it too, by extending its logic, rendered the Egyptian female patient the object of medical advice and prescriptions. The ‘patient’ in this case was the Egyptian housewife, who was addressed directly by Egyptian doctors in the post-WWI Egyptian press. In the explosive number of popular medical journals and women’s pages of mainstream newspapers, the Egyptian homemaker became the medicalised object on whom Egyptian doctors focused their medical expertise to diagnose and, when necessary, treat through their prescriptive advice. More than this, however, was the expectation held by doctors that, as a result of their medical advice, each Egyptian mother would be trained in what was ultimately home-front preventive care, called domestic medicine, that trained Mother to treat her children’s medical ailments as well as rear them in a medically safe environment. Thus, housewives were given the same fundamental task as midwives in their assigned medical role: to nurture the sick. What is striking is how this medical discourse of domesticity was couched in nationalist language and symbolism.

Indeed, by World War I, Egyptian doctors gradually formed into a medical profession – one that Egyptians saw as autonomous from their coloniser-mentors. There is historical evidence to prove that, despite their training under, and subordination to, British medical reforms, Egyptian doctors found in Egyptian medicine a refuge, or better yet, a cultural sanctum that allowed them, through the authority conferred to them by the government and their profession, to formulate their own ideas of medicine, as a collective identifiable group that was culturally Egyptian.

David Arnold uses ‘colonial medicine’ as a theoretical construct to elucidate more clearly the dialectical relationship between the scientific ideas and practices that emanated from the metropole, and the local constraints and imperatives that modified them in India.\textsuperscript{21} This study of Egypt, in turn, borrows and supplements Arnold’s construct by showing how colonial medicine also uncovers the silent actors who stood between metropolitan science and native medicine, such as the colonially trained Egyptian doctors, who helped negotiate this relationship and in the process contributed to the making of colonial science. Use of this construct here is an attempt to recover Egyptian historical agency in the colonial (medical) narrative.
Medical licences essentially became the institutional badge of state authority conferred upon Egyptians doctors to speak on, but more importantly, to intervene, in medical matters. With the significant development of sanitation by the state – including improved water supplies, land drainage and cultivation, and more hospitals and clinics, coupled with an intricate system of strict inspections of institutions like schools and hospitals – to maintain public health (especially against disease epidemics), the role of doctors in ensuring that these measures were executed properly served to enhance their authority and thus their societal importance.  

This heightened institutional authority is a critical point, for it was the foundation on which doctors based their socio-political authority to speak, as an autonomous professional class, about societal matters. In fact, as intermediaries between the state and society, doctors became highly invested in the fate of the state, while at the same time working to secure their own socio-economic interests. This is precisely how Gramscian hegemony functions in society, where the state, consequently, is not the totalising authority that is segregated from society, as many historical narratives understand this relationship. Rather, the state creates loyalties, opportunities and stakes in the hegemony-building process that ally with the interests of native elites. These incentives reconcile the elites with the state, and vice versa.

It is this type of state-society relationship that constitutes the most obvious and critical difference between the formation of a medical profession in Britain and Egypt: it was government action that began and guided the process by which the profession came into existence in Egypt, while in Britain, the profession battled its way toward recognition and legal institutionalisation independent of the state. The relationship between the Egyptian state and doctors, then, was inter-dependent and mutually benefiting.

Furthermore, medical institutions like Qasr al-Aini were critical to engendering a camaraderie of medical professionalism, bound by the Hippocratic Oath, to execute their trade with integrity, honesty and humanity. There is no better indication of this professional solidarity, as well as their growing consciousness as an elite professional class, than the establishment of a medical association. In 1898, the Egyptian Medical Association (EMA) was formed, but died for no obvious reason, only to be resurrected two decades later in 1924. By 1928, this society of 450 members, ‘all of them qualified medical men of Egyptian nationality’, was a medical society that had gained social recognition by both the Egyptian government and citizens.

Their aim and organisation corresponds closely to similar organisations in other countries, with an additional purpose of promoting the use of the
Arabic language in medical literature. To do this, the journal, *al-majallah al-jamiah al-tibbiyyah al-misriyyah*, or *The Egyptian Medical Review*, was established, and appeared ten times per year. The purpose behind the journal, in addition to establishing an Arabic-based medical publication – one more consonant with Egyptian culture – was to secure the recognition of those Egyptian doctors who, previous to this, were forced to publish their medical research elsewhere. Clearly, Egyptian doctors did not share the view of their colonisers that Arabic was incompatible with modern science.

The International Congress of Tropical Medicine and Hygiene, held in Cairo on December 1928 for Qasr al-Aini’s centenary, best exemplifies Egyptian medical professionalism and autonomy, despite colonial domination. The conference shows how Egyptian doctors, in the presence of 2,000 medical men representing forty-four countries, publicly presented themselves as modern professionals, along with their research of modern medicine. Interestingly, the conference presented different opportunities to the British and Egyptians. For instance, to Dr Frank Madden, the British surgeon and Dean of the Qasr al-Aini medical faculty, the conference was seen as one of many opportunities to felicitate British imperialism.25

Contrary to the British, however, Egyptians saw the medical congress as a golden opportunity to show the world, literally, how they, as doctors, saw themselves as equals, professionally and medically, within the global medical community, as well as to exchange ideas, as equal interlocutors, about medical discoveries, developments, challenges and crises surrounding various medical fields. ‘L’Egypte se devait de ne pas rester en arrière de ce mouvement éminemment humanitaire’ [It is in Egypt’s best interests to advance in this largely humanitarian movement], said the Egyptian President of the Congress in his inauguration speech.26 Clearly, the Egyptians saw the conference in a different light to the British.

The 1928 conference thus represents a culminating moment in which the medical training and practice that Egyptians had previously undergone was now put on display by the Egyptians themselves for the world to see as Egyptian achievements. Egyptian modern medicine, as showcased at the conference, was the vehicle through which political ambitions were given vent: for the British, to prove the successes of imperialism; for the Egyptians, to prove their own national achievements. As a result of their professional identity, Egyptian doctors were able to draw from the medical authority – granted by a colonised institution such as Qasr al-Aini – as a foundation on which to base what was ultimately a nationalist discourse of gender, rationalised in medical terms. We see this medico-nationalist discourse of ‘republican motherhood’ clearly when analysing the prescriptive advice offered to the Egyptian wife-mother who, if heeded such advice, became the idealised ‘modern Egyptian woman’.27
There are three general categories into which these popular medical articles can be placed: motherhood, domesticity and female grooming and manner. This paper will limit its discussion to motherhood. There is no shortage of medical advice to Egyptian women on how to be nurturing and competent mothers. Not one article fails to locate the health of the child in any determining way other than on the mother’s health. The medical recommendations offered encourage her to exercise, maintain a healthy diet (using a table that details food categories and proportions), to avoid fatty foods that interfere with digestion and to take ‘special care of herself’. The most common recommendation for all mothers is a daily walk in fresh air, not to exceed one hour.

Like the pregnant woman, the nursing mother is told to take care of herself primarily to ensure that she produces an ample amount of breast milk for her growing newborn. ‘Perfect breast milk’ not only allows the child to sleep comfortably, it also provides ‘him’ with the proper nourishment, on the condition that the mother is active and healthy. Many articles reprimand mothers who are not careful in their feeding habits and are quick to show the risk to the baby’s health of incorrect feeding, such as over- or under-feeding, unscheduled feedings, unpurified milk, unsterilised bottles and feeding when the baby cries.

One article sums it up best: ‘The life during the early childhood years is constantly threatened by bad health; if untreated, this could lead to death. If you [mothers] follow our good health guidance, it will prevent these dangers from happening and it will guide you on how to raise them, as much as experience and medicine has taught us [doctors]’. Many articles warn women who do breastfeed that they should not exhaust their bodies with any other ‘taxing work’, such as cleaning the house, since it reduces their strength and thus the nutritional value for the baby.

Implicit in this discussion of the pregnant and nursing mother is the assumption that the mother’s constitutional make-up is weak – an assumption readily found in Victorian science. One Egyptian doctor explained: ‘In every country, the woman is distinguished from the man by her natural and physical weakness’. In fact, in stark contrast to the tribal woman who could easily deliver her baby, ‘even while walking’, the urban middle-class woman was prescribed a forty-day bed rest, or else ‘she would get sick’.

Not only was her physical strength considered to be naturally weak, but so too was her emotional state. So vulnerable is the pregnant or nursing mother that any imbalance in either state could potentially harm the child, since ‘when she is physically or emotionally sick, so too is the fetus or newborn’. In the case of the expectant mother, the child inherits the ‘weak constitutional make-up from the mother’, unless the mother takes the necessary steps to be both physically and healthy and emotionally
In the case of the nursing mother, ‘if she becomes fearful, sad, angry or undergoes any disturbance to her emotional state, her milk will spoil and may even turn poisonous’.

In fact, one article relates a story of a child’s death caused by the poisonous milk of his grief-stricken mother whose sister had died suddenly. Another summarises an article taken from a London publication that outlines, ‘the best methods of British upbringing, which all Egyptian homemakers should read and benefit from’. In narrating the story of a pregnant English woman who visited an English doctor, this very telling article exemplifies the authoritative power of colonial medicine over Egyptian women’s bodies. Since ‘most pregnant women are lethargic, always tired and weak, and they only sit and day dream all day long, creating things in their head’, the doctor gives the pregnant patient advice, which most of the British women follow. She says:

He advised me to ‘continue physical exercise, go for walks; the thing you should avoid are stories that emotionally disturb or excite you. The Greeks were wiser because they surrounded their pregnant women with beautiful statues and pictures that belong to famous artists, which explains their children’s beauty’. He could not say that this was the reason for their beauty, but he did say that ‘these beautiful things create a nicer environment for a pregnant woman, thus is relaxed and happy, and her mood is moderated’. Since it does these things, it must benefit the health of the pregnant woman.

It is not only that the doctor’s advice is presented as authoritative medical knowledge, but also that this advice was the key to shaping a successful female identity. The pregnant English woman, who saw ‘wisdom and knowledge’ in his advice, discovered that he was correct in his diagnosis. ‘She changed because of his advice, she started to see the beauty of nature the day she went walking, she started to feel compassion and mercy’, whereas before he advised her, ‘she was not very happy and her thinking was not clear’.

By speaking to and about Egyptian women through popular medical discourse, doctors were simply extending the logic of modern medicine as a necessary medical intervention for the benefit of the Egyptian collective body, or ‘nation’ as they themselves put it. While not a consciously political discourse, doctors were certainly conscious and proud of their own sense of ‘national duty’ as both medical experts to cure the sick, and as educators of Egyptian mothers about how illness itself functioned, thus enabling mothers to prevent illness through their daily conduct. This medical duty was both an inherent part of being a medical professional and, in the name of modernity, required further duties of Egyptian mothers. It is in this way that Egyptian culture was ‘scienticised’ in modern, gendered terms, giving credence and legitimacy to a certain class-based vision of...
‘appropriate’ and ‘inappropriate’ behaviours and values assigned in very nationalist terms to Egyptian men and women.

To sum up, the ‘modern Egyptian woman,’ whether she was an Egyptian midwife or housewife, was subordinated by the reconstituted view of woman’s nature as nurturing, caring and maternal, that had been brought about by medical modernisation. Both the externally imposed Anglicising reforms and the hitherto unrecognised internally active participation of the native medical elite performed this colonisation of Egyptian women’s bodies. This study has attempted to analyse the nexus of gender, medicine and nationalism during the colonial period in Egypt. This nexus helps explain the emergence of the ‘modern Egyptian doctor’, a medico-nationalist discourse of domesticity and a culture of gendered, nationalist behaviours and values based on medical rationalisation.

Through a variety of helpful theoretical interventions from gender and science, postcolonial cultural studies and colonial medical history, this study has attempted to argue three interrelated points. First, Egypt’s colonial encounter deepened the symbiotic relationship between modern medicine and state hegemony building begun by Muhammad Ali. The nature of colonial medicine, however, demanded an Anglicisation of Egyptian institutionalised medicine, yet not altogether at the expense of native medical practitioners. Consequently, colonial medicine proved hegemonic not only for the British, but also for some privileged Egyptian males. Second, medical modernisation, as a historical process, inscribed and encoded male privilege within the very inter-workings of medical institutions so that access to power was already circumscribed, gendered and unequal. That is, medical modernisation redefined gender roles and remodelled patriarchal structures to ultimately reify the most powerful ontological definition of womanhood in medical terms, namely that of Mother. This ontological category of the ‘modern Egyptian woman’ at the turn of the century was in many ways a modernised version of a traditional role of domesticity. That medical rationalisations of ‘republican motherhood’ undermined a prior and more active role speaks volumes about the ‘politics of modernity’, or the ways in which modernity has ushered in new and hidden forms of social control over modern women that often go unnoticed due to the presumed and necessary benevolence thought to accompany modern change.35

Lastly, explaining the ‘modern Egyptian woman’ in exclusively medical and nationalist terms is not enough. This study has attempted to show how gender was also implicated by Egypt’s larger socio-economic changes, whose reverberations went beyond the process of modern professionalisation also to include new patterns of consumption, a growing urbanity and consequently changes to (or reifications of) social (read: gendered) space. Russell’s recent study correctly points out that the creation of an
Egyptian ‘New Woman’ – an urban woman who embodied traditional values, yet superseded her grandmother in her ability to run her home, educate her children, serve as her husband’s partner in life and in turn, serve her country by fulfilling all of these duties – was tied to, among other things, new patterns of consumption. Missing in this matrix of capitalism, nationalism and gender, is the role of medicine. This study has shown how medicine provided the authority that solidified capitalism’s relationship to nationalism within a certain popular discourse, precisely by medicalising gender roles in the name of the modern Egyptian nation.

Notes
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8. See Sir E. Cooper Perry, *Report Upon the Hospital and Medical School of Cairo* (Cairo: National Printing Department, 1911).


11. These figures were interpreted from data found in Table 2. Reid, ‘Education and Career Choices’, p. 363.


21. See Arnold, *Colonizing the Body*.


27. ‘Republican motherhood’ is borrowed from Londa Shiebinger, who coins the expression in order to explain how certain Western scientific discoveries in botany and anatomy during the eighteenth century were used as scientific justifications for broader sociopolitical trends. See Londa Shiebinger, *Nature’s Body* (Boston: Becon Press, 1993).

28. al-majallah al-shiiyyah, April 1901.


30. al-balagh al-Ishbi, April 1907.

31. al-muqattaalah, April 1900.

32. al-muqattaalah, January 1902.

33. al-muqatatuf, March 1900.

34. al-muqatatuf, March 1900.
