Islamic Clinics in Egypt: The Cultural Elaboration of Biomedical Hegemony

This article examines the provision of health care by Islamic voluntary organizations in Egypt. It links the development of Islamic clinics to national, regional, and international political-economic transformations of the past decade. The Islamization of medicine is revealed as a particular manifestation of the worldwide spread of biomedicine and not as a revival of earlier Islamic medical traditions. Far from representing an alternative health care strategy that challenges state authority, Islamist medicine is considered as a vehicle for power sharing.

Politics is nothing but medicine on a grand scale.
— Rudolph Virchow

Over the past decade Egypt has witnessed the decreasing significance of state planning and a concomitant privatization of the economy, including its service sector. Within the framework of modernist development strategies, so-called personal initiatives and communal self-reliance enjoy official sanction and mass media popularity. In health care, the trend toward privatization is epitomized by medical establishments that are referred to by a newly created terminology, such as “investment hospitals” (mustashfayat istithhmiyya), “touristic health care” (al-‘ilag al-siyahi), and what may be roughly translated as “healing hotels” (al-fandaka al-‘ilagiyya). Services offered to local patients through such establishments absorb 35–40% of the country’s total health care expenditure (Shawki 1987:17). Aside from the relatively limited number of local patients who resort to these high-priced, high-tech medical centers, a large and increasing number of Egyptians seek medical care in clinics and/or hospitals established by religious and philanthropic associations.

The spread of Islamic medical organizations, contextualized within the political-economic transformation of Egypt during the past decade, constitutes the focus of this article. Within the framework of Egypt’s “economic opening” and the regional petro-economy, Islamic medical services emerge as a cultural elaboration of biomedical hegemony. Stripped of its cultural facade, Islamic health care does not appear to stand on its own but is firmly supported by the well-entrenched pillars of high-tech, curative, individually centered biomedicine.

Methodologically this study focuses on the political-economic circumstances surrounding the proliferation of Islamic clinics, rather than the microsociological processes involving their operation. This delineation of the scope of...
analysis entails an expanded definition of the "field" of anthropological inquiry in which the researcher is "always already in the field," unrestricted by the "distantiation" of routine "participant-observation" (Koptiuch 1985). Thus, while the following analysis is partially based on occasional visits to Islamic medical centers and on "emic" interpretations derived from interviewing an opportunistic sample of physicians and patients, as well as on the additional positivist analytical element of statistical data, it transcends the surface form of the phenomenon under investigation. The primary purpose of the analysis is to address the dialectical relations that determine this phenomenon. This perspective takes us well beyond the confines of Cairo mosques, the neo-orientalist obsession with "Islamic fundamentalism," and "empirical reality" to the "recompradorization" of Egypt, the regional petro-economy, and associated international power relations (cf. Amin 1988). As Foucault has described 18th-century European health care developments, "It is in . . . these materialities, which are at once political and economic, that the 'physical' process of transformation . . . is inscribed" (Foucault 1980:182; cf. Onoge 1975).

Following an account of the spread of Islamic medical organizations, the article addresses the question of whether this development represents a form of Islamic medical revivalism (cf. Banerji 1986; Elling 1981a; Horn 1985). The historically informed negation of this proposition is followed by considering the phenomenon under discussion as part of an Islamist trend in Egypt. Turning to the economic correlates of this development, our attention necessarily widens to the regional petro-economy. I conclude by examining Islamist medicine as a culturally and historically specific elaboration of biomedical hegemony.

**Islamic Associations and Health Care**

The eclipse of the Nasserist welfare state has been accompanied by a proliferation of a variety of philanthropic and voluntary associations. After the 1967 war, the rapid increase of such organizations was sustained during the 1970s and 1980s, and their number reached an estimated 13,000 by 1986 (Amer 1986). Of these numerous voluntary organizations, 3,000 are registered as religious associations, about 80% of which are Islamic (Amer 1986).

Many of the Islamic associations registered with the Ministry of Social Affairs are multifunctional organizations that engage in philanthropic activities and offer various services (Bianchi 1984:24). According to the director general of the General Union of Voluntary Associations, Islamic associations have been "most successful" in the provision of health care through clinics attached to mosques (Amer 1986). The medical services offered by Islamic clinics, including those not attached to mosques, are supervised by the Ministry of Health.

Official statistics on the number of Islamic clinics are far from exact; figures range from 1,000 to 2,000 nationwide. The majority of these clinics are located in urban areas, with an estimated 300 to 350 in the greater Cairo area itself (Hamady, Sadek, and Bird 1987:23). Numerical estimates aside, it is evident that many Egyptians turn to Islamic clinics for medical care. These medical establishments are frequented by the poor, as well as by middle- and even some upper-income patients.

Most Islamic organizations offering medical services have outpatient polyclinics; only some provide hospital care. In general, Islamic clinics enjoy the rep-
utation of being "equipped with the most modern instruments including kidney [dialysis] machines and ultrasound diagnostic instruments" (Amer 1986, translated by the author). The diagnostic center of the Mahmoud Mosque, by far the most prosperous of Islamic philanthropic organizations, boasts a polyclinic with various specializations: an X-ray department; a laboratory equipped for photometric, bacteriological, and parasitological analysis; and a laser unit for eye surgery.

While some Islamic clinics provide patients with the services of specialized physicians and supportive medical equipment, others are known to suffer a shortage of specialists and equipment (Adel Ganam, M.D., personal communication, 1987). Thus, in contrast to the reputation for efficiency and reliance on advanced medical technology enjoyed by Islamic clinics in general, some physicians have noted certain outstanding deficiencies related to personnel and equipment. Some affiliates of Islamic clinics have called upon the Physicians' Syndicate to supervise these clinics (El-Sehety 1987).

Physicians employed in Islamic clinics, including female physicians, are paid a monthly salary commensurate with experience. Additional remuneration is derived from a fixed percentage of the medical fees paid by patients (Ganam, personal communication, 1987). This income compares favorably with employment in government health services. However, the work of physicians at Islamic centers is not regulated by legally binding contracts. This has prompted some doctors to call upon the Physicians' Syndicate to negotiate for them in contractual matters (El-Sehety 1987).

The medical services offered by most Islamic clinics may be regarded as an intermediate form between "investment medical care" and governmental services that are offered free of charge in the clinics of the Ministry of Health. For people unwilling to endure the hardship of resorting to government medical services, the fees at Islamic medical centers are far lower than payments to private, independent physicians. In addition to low cost, both the relatively courteous treatment extended to patients in Islamic clinics and their convenient locations are identified as sources of their popularity. This popularity has prompted some private physicians to complain about the competition posed by Islamic clinics (Amer 1986).

Islamic Clinics: A Form of Medical Revivalism?

The designation "Islamic clinics" may prompt the question of whether the services offered by these establishments constitute a form of Islamic medical revivalism. When this question was posed to an official of the national Physicians' Syndicate, it provoked the following unequivocal response:

These clinics do not [practice] Islamic medicine. Medicine, like any other aspect of Islamic civilization, has declined. These clinics [practice] Western biomedicine, and there is nothing Islamic about it. . . . If you are sick, you cannot go to the government doctor, because he usually does not show up, or if he does, he may give a quick diagnosis [that] a patient may distrust. But going to clinics attached to a mosque arouses people's sentiments of trust. [Hamady, Sadek, and Bird 1987:22, translated from the Arabic by Said Sadek]

It may be noted that the elicitation of "sentiments of trust" in patients of contemporary Islamic clinics resembles the concern with "satisfactory rapport
with patients,’” demonstrated in Ibn Sina’s (Avicenna’s) advice to physicians, as illustrated in his Poem on Medicine (Krueger 1963:86, italics in original). But such superficial resemblance is coincidental. So is the well-recognized influence of medieval Islamic medicine on the medical theories and practices of contemporary health care specialists (cf. B. Good 1977:29; M. Good 1980; Greenwood 1981). The medicine practiced in the Islamic clinics of today does not involve any commitment to the revival of Galenic/Prophetic traditions of former historical periods. The theological form of Avicennianism and the holistic orientation of Sufi medicine have no place in today’s Islamic clinics, and neither do other traditional forms of indigenous medicine, whether al-Razi’s or the ancient Bedouins’.

Beyond the religious label, the establishment of Islamic clinics does not resemble the type of medical revivalism described for other parts of the world, notably India (Burgel 1976; Gran 1979; Leslie 1976). One does not detect even a partial commitment to a renaissance of Islamic medicine. This difference between the Egyptian case and revivalist movements in other parts of the world has also been noted for an earlier period of Egyptian history. Peter Gran (1979) has observed that the attitude of 20th-century Egyptian sheiks toward modern physical medicine contrasted with that of Asian revivers of indigenous medicine, who contended that positivism and allopathic medicine have roots in Indian tradition. This observation has prompted Gran to raise the question, “could the merchant sector of Bengal, and especially Calcutta, have been stronger socially and politically vis-à-vis the ruling alliance of British and landowners than was the case of Egypt?” (Gran 1979:346). In extending the logic of Gran’s question to current trends in Egyptian health care, we turn to consider the relationship between Islamic organizations and political authority.

Islamic Health Care and Political Authority

The spread of Islamic clinics may be regarded as a manifestation of the so-called Islamic Alternative, Resurgence, or Awakening (Abu-Lughod 1982; Al-Yassini 1986; Cudsi and Desouki 1981; Zakariya 1984, 1987). The increase in medical services associated with Islamic institutions is part of the generalized implementation of the slogan, “Islam is the Solution.” This trend toward Islamization is reflected in finance, industry, and education, as well as in social science debates, including anthropological discourse (Fahim 1987; Hussein 1985; Morsy et al. 1987). Egyptians have come to know the Islamic garden, the Islamic sports outfit, and the Islamic vote in the national medical professional association known as the Physicians’ Syndicate. Islamic services include child care centers, banks, and educational services offered to university students, including medical students.

In considering the current proliferation of services offered by Islamic organizations, it is imperative to recognize the heterogeneity of such organizations and thereby avoid the orientalist tendency to reify Islam as a unitary social force (Ibrahim 1982; Said 1981). Indeed this realization “encourages far greater caution in generalizing about the likely political consequences of greater collective action among Muslims than has been evident in so many anxious accounts of the ‘Islamic revival’ ” (Bianchi 1984:19). With regard to health care, the differentiation of Islamic groups helps illuminate the social character of Islamic medical services.
and their role in legitimating existing political-economic structures, albeit in Islamic garb.

The numerically significant type of religious organization with which Islamic clinics are associated fits midway along a continuum of Islamic groups with regard to their relationship to the state, with the semi-official complex of Al-Azhar at one end of the continuum and a collection of illegal secret societies of Islamic "militants" at the opposite end. The variety of religious organizations that fit along this continuum have been promoted or at least tolerated by the state in its attempts to absorb some of the post-1967-war rise in popular religiosity (Bianchi 1984:20), to de-Nasserize Egypt, and generally to undermine the efforts of the Egyptian left (Hanafi 1982). These intermediate types of religious associations, including those offering medical care, are groups that usually begin as voluntary, private organizations but often find their activities subject to state intervention and even generous sponsorship (Bianchi 1984:2).

This analytical differentiation of types of Islamic associations should not, however, obscure the overlap and shifts in membership of these groups over time. It is also worth noting that election to governing bodies of various academic and professional organizations (including state-chartered student unions and professional organizations) is facilitated by affiliation with religious groups. The case of a former "prince" (amir) of one of the so-called Islamic Associations (jam'at islamiya) illustrates this fluidity in membership and the close association between politics and religious affiliation. This physician, a prominent member of the Physicians' Syndicate, editor-in-chief of the Syndicate's publication Al-Atiba, vigorous campaigner for political office under the slogan "Islam is the Solution" (Al-Iryan 1987:3), and member of the Islamic Alliance in the People's Assembly, is also an advocate of Islamic medical care (Abdel Hadi, M.D., personal communication, 1987).

The political significance of Islamic associations' "public service" orientation has not gone unnoticed by state agencies. In addition to the Ministry of Interior's supervision of financial contributions to Islamic philanthropic organizations (El-Sehety 1987), such organizations are subject to tight bureaucratic controls. The increase of state aid to Islamic private organizations and their eventual annexation represent additional means of tightening government regulation (Bianchi 1984:27). In short, the state encourages Islamic service organizations to the extent that it considers their services to be a contribution toward placating the masses, but it always keeps these organizations under surveillance through various governmental agencies.

Beyond regulation of the activities of Islamic associations, the state itself lends legitimacy to the Islamic orientation. Its adoption of the "Islamic Alternative"—as reflected in legislative discourse, media propaganda, and the Sadatist slogan of "Science and Faith" (Hanafi 1982)—extends to health care. For example, the cornerstone of an Islamic center was laid in the presence of government officials as part of celebrations to commemorate the October victories in the governorate of Behera. Not unlike the famous Islamic Center of the Mahmoud Mosque Association, this state-sponsored Islamic center is designed to house a school for memorization of the Quran, a training center for girls, an Islamic library, and of course a clinic (Al-Ahram 1987a).
While recent developments in the Arab world and adjoining areas have underscored the significance of religious symbols for political opposition, it is also worth remembering that religion can help individuals and groups gain legitimacy within existing power structures. Under close state supervision the charitable health services offered by Islamist groups help maintain an indispensable component of the social welfare package and thereby simultaneously help such groups gain legitimacy in, and affirm the legitimacy of, the social system (cf. Jacobsen 1986:131).

As expressed in a publication of a major Islamic center (Mahmoud Mosque n.d.:16, original text in English)—and contrary to radical Islam (El-Khatib 1982)—charitable, reform-oriented Islamic associations "do not dream to reform a nation, but to reform man. . . . Islam is not a revolution, nor a coup d'etat but . . . an illumination and revival of the heart and conscience." Within the framework of such individually centered orientations and as reformist, state-regulated voluntary associations, Islamist groups do not represent an explicit antagonistic challenge to political authority (Zakariya 1987:24–27). Indeed, within the existing power structure the service orientation of Islamic associations provides opportunities for members to gain legitimacy and consequently to share power. Economic factors related to national and regional developments enhance this potential.

**Health Care and the National and Regional Economies**

Changes in Egypt's health system are inseparable from shifts in national economic policies and development strategies. As a result of Sadat's Open Door Economic Policy (ODEP), large investments in newly created economic enterprises have come either directly or indirectly from petro-based wealth. The economic power wielded by oil-rich Arab regimes, which ideologically approve of the "Islamization" of Egypt, has boosted Egyptian Islamic economic activity (cf. Aly and Wenner 1982: 346–347). Islamic investment companies, known for their ties to the Gulf (Abdel Fadil 1987a), provide Egyptian investors (including those who had initially accumulated wealth in the oil-producing countries of the region) with the highest return on their savings. Gulf finance capital and Egyptian Islamist capital unite not only in Egypt but as far away as the Bahamas, where the Islamic Bank of Al-Taqwa (Piety) is being established (Anis 1987). Meanwhile, back in Egypt the image of the "piety" of petro-sheiks is preserved through various means, including direct and indirect contributions to Islamic philanthropic organizations.

Petro-dollars are also channeled into the Egyptian health sector through "curative tourism" (al-siyaha al-ilagiya). Luxury health care is said to save the country hard currency that would otherwise be spent by Egyptians seeking quality medical care abroad. Proponents of this form of health care also point out that patients from other parts of the Arab world may be willing to forgo the care provided in Western medical establishments in favor of comparable services in Egypt.

Within the framework of Egypt's Open Door Economic Policy (ODEP), political considerations have no doubt helped preserve public medical services. However, once unleashed, market principles have managed to creep into the health sector and affect it adversely. Even people's desperate need for body parts
for transplantation is now regulated by the economistic principle of supply and demand (Al-Ahram 1987b:3). By the admission of an official consultative body, public health services are in a state of constant deterioration. Moreover, the national health insurance program is deemed inadequate. Coverage is restricted to three million Egyptians and the remaining majority is said to be "exposed to the dangers of free health care" (Amin 1987).

A report prepared by the Service Committee of the nationally elected consultative body known as the Shura Council indicates that the proportion of resources allocated to health care in the national budget has decreased by half during the last 20 years (Amin 1987:18). As a result, patients requiring surgery in state hospitals may have to wait for months or even years. The general deterioration of government facilities extends to medical equipment. Medication is generally unavailable in hospitals, and physicians attend to their patients only irregularly (Amin 1987:19).

A survey of state expenditure on health care during the period between 1960 and 1985–86 shows that the budget allocated to the Ministry of Health during 1960 amounted to about 17.7 million Egyptian pounds (L.E.), which constituted 4.6% of total state expenditure. This increased to about 31.3 million L.E. in 1965, amounting to 5% of expenditure. During the course of the current Egyptian regime's program of "Peace and Prosperity," while state expenditure more than doubled to nearly 402.5 million L.E. between 1980 and 1986, the increase for health services amounted to no more than 0.9% of the total state expenditure. Figures for 1984 show that while the state spent 12.2 million L.E. for the treatment of about 5,000 patients inside Egypt, it allocated 1.3 million pounds (in foreign currency) to cover the medical expenses of 287 persons outside of the country.

Inside Egypt the skewed distribution of medical facilities is indicated by their concentration in the major urban centers. Differential distribution extends to both private and public sectors. In 1985 private hospital beds, which serve those who can pay for treatment, amounted to 8,491. The public sector, which presumably serves the majority of Egyptians, had no more than 7,297 beds and is well known for the inferior quality of its health care. Thus, while the average Egyptian may expect no more than about eight pounds' worth of state support to cure his or her bodily afflictions, a select group of Egyptians each receives about 2,500 pounds for treatment inside the country. As for the even more privileged few "special cases," who receive medical treatment outside of Egypt at state expense, each is allocated an average of 4,000 pounds (Amin 1987:20).

Private medical services do not represent a real alternative for the majority of Egyptians. As the public confronts rising health costs, neither the state nor the Physicians' Syndicate is willing to regulate physician or hospital fees. Private hospitals, and particularly those established within the framework of investment legislation, remain off limits to people living on fixed incomes and unable to raise their income in proportion to the soaring inflation rate.

Egypt's physicians have not been insulated from the crunch of the country's economic difficulties. With the implementation of Sadat's liberal economic policies and the decline of nationalistic fervor, capitalist incentives have prompted some of Egypt's better trained and experienced physicians to seek their fortunes outside their homeland, either in the West or in the oil-rich states (Baker
1978:233). Not unlike their classmates from other disciplines, young medical school graduates are often forced to seek employment away from their field of university training and venture into the world of the multinational service sector. As indicated in a publication of the Physicians' Syndicate, graduates of Egyptian medical schools 'drag the title 'doctor' . . . to restaurants, hotels, night clubs, and . . . the steps of airplanes; perhaps the only profession not adopted by physicians so far . . . is that of undertaker' (Salem 1987:33).

Given the despair of most patients and the increasing problems of young physicians, Islamic clinics represent a most welcome development on the health care scene. Indeed, as noted by Dr. Shawki, secretary of the Physicians' Syndicate and director of seven clinics associated with an Islamic association, the "bottom line" for the success of Islamic clinics is that "They offer inexpensive medical services and provide employment to . . . medical school graduates" (Hamady, Sadek, and Bird 1987:2). A similar assessment of the significance of Islamic clinics was presented at a meeting of the Physicians' Syndicate. The director of the medical center of the Mustapha Mahmoud Mosque presented Islamist medical care as an alternative to private and investment hospitals. He stated,

We used to dream while we were still medical students that we would be an army in the service and protection of the [Egyptian] people, because physicians cannot live in isolation from society. But after graduation we found out that the world of medicine is governed by the law of the sea. The large fish eat the small fish, and thousands of young physicians cannot establish clinics. They can find no place to work but the medical centers of religious associations. These [organizations] receive large donations; [such centers] are therefore the only hope left to the sick and to young doctors who can work in a spirit not found in any other place, provide good service, and practice within a correct spiritual framework. [Yunis 1986; translated from the Arabic by the author]

Moreover, through work in Islamic clinics, young doctors become acquainted with patients who may be willing to follow them to their private practices, once material resources allow such moves.

In considering the sources of income that allow Islamic associations to alleviate the suffering of patients, as well as the economic hardships of young doctors, it is important to note that Islamic voluntary associations are linked to what has become known as the Islamic economic sector, which includes Islamic banks, industrial enterprises, and investment companies. In addition to "special payment plans," Islamic clinics receive donations from the private sector (El-Sehety 1987). In at least one known case, a very prosperous Islamic association that provides medical care was awarded a grant of six million pounds from a European source (confidential personal communication).

Contributions to Islamic philanthropic organizations, including those that provide medical services, also derive either directly or indirectly from the petroleum wealth of other Arab countries where Islam has been a significant legitimizing device for the existing political order. In addition to direct charitable contributions from the Gulf, Islamist medicine is supported by Islamic investment companies with well-known connections to the finance circles of the petroleum-exporting countries of the region (Abdel Fadil 1987a). The Al-Rayan investment group supports a philanthropic Islamic hospital which bears its name. In other cases the Islamist private sector supports Islamic clinics and the related Islamist-dominated
Physicians' Syndicate. In contrast to the Journalists' Syndicate, which refused the offer of an interest-free loan from the Al-Rayan Islamist investment group to support a housing project (Aref 1987), the Physicians' Syndicate openly advertises its cooperation with an Islamist construction firm and the Faisal Islamic Bank on a housing project for physicians (Hamady, Sadek, and Bird 1987:26).

Through the generous support of Islamists within and outside of Egypt, the "Islamic Alternative" in health care is presented as an effective means of addressing the unmet medical needs of the underclass. In fact, Islamist medicine is perceived by some, and explicitly defined by others, as the private alternative to the state's program of health insurance, a remnant of Nasser's Arab Socialist experiment (El-Sehety 1987).

Islamic Clinics: Cultural Facade for Global Biomedicine

The biomedical orientation of Islamic clinics, noted above, is but an extension of a positivist medical tradition that took root in Arab society from the 16th through the 19th centuries in conjunction with the rise of capitalism and the world market (Gran 1979:340). Within the framework of medical pluralism, Yunani medicine became progressively amalgamated with Western, positivist allopathic medicine (Gran 1979:340). In the 19th century the latter tradition gained official sanction during the reign of Mohamed Ali. Modern medical science was introduced within the framework of Egypt's earlier state capitalist experiment, and a medical profession was established through the activity of the Qasr al-Aini Medical School, which was founded in 1872, prior to the British occupation (Sonbol 1981).

In the course of Egypt's more recent Nasserist period, aside from the regime's short-lived interest in Sufism, official support of positivist medicine was maintained (Gran 1979:347). Spiritual medicine and other variants of antecedent medical traditions continued to form an important part of Egypt's pluralistic medical system but never enjoyed legal protection. Within the framework of state capitalist development, the emphasis shifted from health as a facet of colonial exploitation (cf. Gruenbaum 1981; Morsy 1986a) to that of health as the key to increased productivity and higher income. During the 1960s much of the growth in investment consisted in the development of a basic health infrastructure (Waterbury 1983:218–219).

Turning to the Sadatist regime, Western-style medical care became a much flaunted symbol of the state's modernist orientation. Within the framework of the ODEP, United States health care financing constituted an important component of the aid package awarded to the Egyptian regime for its "courageous" political initiatives and associated strategy of privatization of the economy (Morsy 1986b).

In modernizing its health sector, Egypt has relied on bilateral foreign aid and technical assistance projects involving a number of Western nations (Office of Technology Assessment 1984:306). USAID's general strategy of "involving private sector providers and private sector financing" (Tinker 1984:6) was certainly compatible with, if not conducive to, the privatization trend set in motion by the Open Door legislation of 1974.

Official commitment to the reintegration of Egypt into the Western-dominated global economy and associated regional petro-economy prompted the flow of international private capital into the country's health sector. During the last
decade a number of "disease palaces" were established with private funding from Egyptian, Saudi, Kuwaiti and other Gulf States, North American, and European sources (Office of Technology Assessment 1984:599).

Although different from capital-intensive, market-oriented entrepreneurial medicine, Islamic clinics have also attracted international funding, albeit in the form of charitable contributions (particularly from the Gulf). With regard to international aid, as noted above, funding from a European source is known to have been granted to one of the more prosperous Islamic medical centers. As for other international funding, while it is known that USAID "is the largest governmental institution which provides financial aid and technical support to non-governmental organizations in Egypt"—including some which have provided health care to 672,340 Egyptians (Amer 1986)—it is not clear whether these organizations include Islamic associations.

Current attempts to "upgrade" health services in Egypt have been influenced by the so-called "developed country model." Thus, with support from foreign assistance programs, which are a major mechanism of medical technology transfer, the Ministry of Health "has opted for . . . investments in high-cost curative care services (hospitals and emergency medical care) that offer visibility and professional satisfaction to an expanding group of physicians" (Office of Technology Assessment 1984:206).

Egypt's imports of medical equipment and supplies, which amounted to $40 million in 1980, make it a somewhat important customer in the Arab market for medical equipment and supplies. As indicated in a U.S. government publication, AID health programs in Egypt have certainly provided commercial opportunities for U.S. firms (Office of Technology Assessment 1984:344). Other Western firms, notably British suppliers, have also been the beneficiaries of Egypt's Western-supported health modernization efforts. British export firms that have become increasingly involved in the production of medical "export packages" (Doyal and Pennel 1979:270) are active in the Egyptian market (Morsy 1986a:57). Thus, the modernization of Egyptian health services is helping to "intensify in the [British] national interest the export of British health systems and products" (Doyal and Pennel 1979:270).

In accordance with state regulations, Islamic clinics contribute to the consumption of Western medical technology. According to the head of the Board of Directors of an Islamic association that operates a clinic, "the Ministry [of Social Affairs] stipulates that [clinics] buy equipment from the West, regardless of its performance and cost relative to equipment from other sources" (El-Sehety 1987). In addition to reflecting a general current trend, the high-tech orientation of Islamic clinics is an extension of the attitude of earlier Islamic modernists who propounded a reform concept of Islam and stressed its compatibility with the adoption of scientific and technological innovations (Adams 1968).

Beyond similarities related to material health care resources, Islamic clinics partake of the dominant positivist, individual-centered medical orientation. Not unlike Western biomedicine, the "delivery" of health care by the certified professional "providers" of Islamic clinics reduces socially induced afflictions to individual-centered pathologies subject to "cure" with the aid of advanced scientific technology.
The individual focus of Islamist care is illustrated by a publication of an Islamic medical center, which reads, "we want to perfect the individual and through the individual we can perfect the family and the society" (Mahmoud Mosque n.d.:16). Thus social problems are displaced to the realm of individual behavior management. Through the reification of disease, attention is focused on the condition of physical illness rather than the social relations that affect it (cf. Stark 1982:50; Taussig 1980).

In sum, far from representing an attempt to merge traditional and modern medical approaches (cf. Elling 1981a) (not to mention linking disease to its political economic roots), contemporary Islamist medicine only veils the hegemonic international tradition. Islamic clinics are thus no different from Islamic banks, Islamic investment companies, and Islamic women's apparel "imported from London" (Abdel Fadil 1987b).

Conclusion

The current association of health services with Islamic institutions has precedence in Egyptian history. Recorded for earlier periods, this connection survived the decline of Islamic medical hegemony (cf. Heyworth-Dunn 1938; Landwith 1905; Sonbol 1981). More generally, the association of medical care with religious/ethnic groups was maintained up to the time of the 1952 Nasserist army coup. Prior to the nationalization of major private medical establishments, a number of hospitals had been established and managed by various religious and ethnic groups. These included the Coptic, Jewish, Italian, and Greek hospitals. Not unlike today's Islamic clinics, these medical centers bore greater resemblance to Western denominational medical establishments (such as those established in the United States during the late 19th and early 20th centuries) than to antecedent indigenous forms of health care (cf. Starr 1982:170).

Beyond the provision of biomedical services, contemporary health programs provide opportunities for the appropriation of power. The welfare orientation of today's Islamic clinics, shared by the Muslim Brotherhood during the 1940s, provides "an umbrella for political activity" (Amer 1986; cf. Aly and Wenner 1982:338; A. El-Bayoumi, personal communication, 1974; Mitchell 1969:37, 76, 202). Similarly, within the framework of Nasser's Arab Socialism the state also resorted to health services as a conduit for ideological messages (Baker 1978; Berger 1962:193; Mayfield 1974; Waterbury 1983:218–219; cf. Waitzkin 1983:141). Even as Sadat proceeded to build his society of "personal initiatives," state support of health care was not abandoned, given the great symbolic value of health care in politics (Waterbury 1983:218).

Today the politicization of health care is not limited to Islamic associations. The opposition press, including publications of Nasserite, Wafdist, and Islamic Alliance factions, carries advertisements of free medical services offered by professionals affiliated with the respective political parties. To the extent that such activities are not deemed as challenging to the existing social system, they are allowed to continue. Indeed, it is precisely such non-threatening expressions of an Islamic or any other "Alternative" that the state is likely to welcome as support in its efforts to maintain the peace (cf. Hanafi 1982). Far from representing "cultural anomie" (Tibi 1983:7) or from preventing Egypt from "looking outside, particularly Northwestward" (Abdel-Khalek 1981), Islamist medicine represents
a cultural elaboration of global hegemonic biomedicine and a culturally appropriate mode of preserving health care as a component of the state-controlled welfare package (cf. Jacobsen 1986:131). Within the existing power structure, the placebo effect provided by religious symbolism (cf. Elling 1981b) affords the professional "providers" of Islamist health care the opportunity to share power as the state's ideological metamorphosis increasingly lends legitimacy to their efforts.

NOTES

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1Ms. Iman Hamady, a graduate student in the American University's Department of Sociology-Anthropology-Psychology, is preparing to undertake an ethnographic study of Islamic clinics.

2Professional associations, including the Physicians' Syndicate, have well-recognized political functions. Conferences, lectures, and publications of such associations attest to their political character.

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