
TECHNOSCIENCE IN ISLAMIC SOCIETIES

Islam, Fatalism, and Medical Intervention: Lessons from Egypt on the Cultivation of Forbearance (*Sabr*) and Reliance on God (*Tawakkul*)

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Abstract

One of the most fundamental ways that religious devotion is held to be "anti-biotechnology" is in its emphasis on submission to divine will. This article seeks to re-orient discussions of religious "fatalism" through ethnographic analysis of terminally-ill dialysis patients in Egypt who argue that they would rather "accept God's will" than pursue kidney transplantation. I argue against the presumptions that this is a religious constraint on a potentially beneficial treatment, or that this reaction is merely a "comfort mechanism" to appease those without access to treatment. I argue that we should not think of people's perceptions of the amount of control they can exert over their lives in terms that would place analyses of social benefit and religious belief in opposing or even in discretely separate categories. I also demonstrate that, far from being passive, the disposition of accepting God's will must be actively cultivated through work on the self. [Keywords: medicine, Islam, Egypt, fatalism, bioethics, organ transplantation, illness, suffering, divine will]

This article draws upon fieldwork among poor dialysis patients in Egypt (2002-04) to revisit questions about fatalism and medical treatment. I analyze when and under what conditions devout Muslims in contemporary Egypt appeal to utter submission to divine will and when they seek particular medical interventions. The cultivation of steadfastness is highly valued in many religious traditions. Yet many historical accounts by European travelers and Orientalist scholars describe pious Muslims as “fatalists” for cultivating this disposition,¹ a descriptor that has persisted in the contemporary Western media.² It is critical to unpack the various implications of the charge of fatalism as well as the social realities that it masks for a better understanding of the practices of both Islam and biomedicine.

I argue in this article that the common formulation of passive Muslim fatalism grossly misunderstands the ways in which religious dispositions are embodied. Dispositions of acceptance of divine will are far from passive and must be actively cultivated. Further, such a disposition is not necessarily contrary to acting in the world. Whether and when to ultimately cultivate such a disposition is necessarily contingent upon how much control patients feel they have in the face of illness and other trials, and on whether they have any options that would really provide an appropriate “solution” that could be lived with medically, socially, and spiritually.

Among many Western observers, the Islamic theological premise that believers should utterly submit themselves to the will of their omnipotent Creator is taken to be a causal determinant of the way that Muslim adherents live their lives—the assumption, among polemicists, being that they are condemned to irrationality, with little incentive to work for social progress in this world. Not only is Muslims’ supposed proclivity to fatalism said to be politically dangerous, but it is also imagined to be a major impediment to the development of scientific knowledge and to the reception of new technologies.³ If bad conditions are accepted as a sign of God’s will, then why should the faithful develop the technological means to improve them? If illness is a test of faith, then should devotees not seek medical treatment?

Social scientists have generally had poor critical tools for analyzing how believers face and experiences these questions, particularly given the prevailing secularist presumptions in academia about human agency and the normative subject who transcends cultural norms and religious bounds (Asad 1993, Asad 2003, Mahmood 2005, Hirschkind 2006). Faith in divine will has often been interpreted as passivity, inaction, or false con-

sciousness—a functionalist mechanism to alleviate poverty and suffering. Or, too often, religion is assumed to be a tool of manipulation by the powerful to keep the disadvantaged downtrodden. Another common assumption is that religion acts as a “constraint” against the presumed benefits of science and technology, or that it constitutes “resistance” against the “Western” origins of technoscience. My argument is not that religious devotion never takes such forms, but that *when* and *how* submission to God’s will is articulated, experienced, and cultivated in particular places and times must be explained rather than assumed.

Clearly there are particular scientific methods, theories, and technologies that are embraced and others that are shunned by religious scholars and self-described devout practitioners. Even the same technology could be shunned under a certain set of circumstances and appear to be beneficial under another. Throughout the course of my fieldwork on organ transplantation in Egypt, I came across several transplant surgeons who admitted to me that they themselves would never undergo a transplant operation, because they believed that only God owns the body. In grappling with a way to render this in my analysis, I found that our analytical toolbox in the social sciences lends us to view these discrepancies as “ironic” at best, or “hypocritical” at worst. This has largely to do with our tendency to think of religious ethics as a set of codified rules that maps onto or constrains practice, rather than viewing religious ethics as an embodied aspect of the self that is contingent upon dynamic social processes (Hamdy 2006).

The view of fatalism as irrational, passive, and anti-science is held not only by outside Western observers, but is also part of an internal debate among Muslims, including one that preceded the presumptions of Western modernity. Muslim religious scholars have long debated the terms under which one should cultivate steadfastness, under what circumstances one should seek technological intervention—and here I focus on medical intervention in disease and suffering—which interventions are virtuous, and which interventions turn believers away from dispositions of God-consciousness.⁴

In the modern period, under the influence of colonial discourse, 19th century Muslim reformers defended Islam against the charge that Muslims were doomed to colonial domination because of their “anti-scientific” and “fatalistic” worldviews, most famously put forth by the French Orientalist Ernest Renan (Keddie 1972, Rahnema 1994). Yet rather than argue that Muslims were in fact reliant on God, a disposition that was *not* necessarily

backward, the Reformers, like the Orientalists, identified fatalism among the “masses” and argued that it was incorrect Islamic practice (Hourani 1962, Iqbal 2002).⁵ In modern Egyptian nationalist discourse, passive fatalism, an allegedly faulty religious belief, and anti-science were conflated as one and the same problem.⁶ Particularly in institutions of biomedicine and public health, state officials singled out passive fatalism as a dangerous disposition among the populace, particularly the rural peasantry.⁷ Fatalism continues to be posited by the Egyptian state as a significant obstacle to progress, unless corrected via state authorized religious and scientific pedagogy, such as those in state-approved mosque sermons, popular films, schools, and public health campaigns (Hourani 1962, Armbrust 1996, Starrett 1998, Hamdy 2005, Hirschkind 2006). In these state discourses, utter reliance on God is often regarded as a static quality, while feelings of active responsibility (toward citizenship, scientific inquiry, or self-improvement) are said to move people and society forward.

I seek to re-orient the discussion of fatalism to two ends. First, I argue that the disposition of submission to God’s utter will (*al-tawakkul*) is not a “passive” form of fatalism that negates human agency, but is in fact a disposition whose achievement requires active and persistent work on the self. Throughout academic debates about the connections between Islam and fatalism, there has been little discussion about *how*, precisely—through what practices and orientations—Muslims come to embody dispositions of belief, particularly that of utter reliance on God.⁸

Secondly, I argue that we should remain attentive to when, and under what conditions, acceptance of God’s will should be cultivated. Toward this end, we should not think of people’s perceptions of the amount of control they can exert over their lives in terms that would oppose structural constraints and religious belief. Our tendency to view structural, material conditions as entirely separate from religiosity leads us to interpret believers’ invocations of divine will as instances of “false consciousness,” in which people are “really” oppressed by limited structural and material conditions, but appeal to religious reasoning as a “comfort mechanism.”

I substantiate these arguments through an ethnographic analysis of how Muslim patients in Egypt articulate their use or disuse of particular biomedical technologies. My work among terminally-ill kidney failure patients in Egypt and the complex ethical reasoning that they employ reveals how their religious logics intersect with their assessment of social and medical risks and benefits as they face life-and-death decisions about their medical care.

As they face limited options for recovery, they actively work upon their selves to cultivate dispositions of acceptance of God's will.

Sticking with What Works

In the Tanta University Hospital dialysis center where I conducted fieldwork on kidney failure in Egypt (2002-04), I sat with a group of young men in their twenties who were following a soccer match on the small grainy television while they received their dialysis treatment.⁹ Many were poor, either agricultural laborers from the countryside or low-income workers in Tanta's factories and service industries. They all received compensation for their dialysis treatment directly from the Ministry of Health's program, which covers the full cost of dialysis for the poor.¹⁰ One of these men, Muhammad, told me that he was born with only one kidney and suffered from hypertension. One day, he took the wrong pill for his high blood pressure which resulted in acute renal failure. The physicians had later told him that if he had taken *two* pills (the regular dosage) he would have died immediately. But for some reason he only took one and ended up in a coma.

Muhammad was not particularly religious before his diagnosis but since that time, seeing his young life suddenly and drastically changed, he said that he would never miss any of the five obligatory daily prayers (*al-salat*), nor would he forget to continuously thank God for still being alive.

Before his illness, he had worked in a small clothing store with a young woman and had recently asked her family's permission to marry her. He said that she accepted the proposal, and that her mother also had accepted him into their home:

This was last Ramadan. But it was her maternal uncle who opposed. He said to me, "Look son, this isn't because of the way you look, or the fact that you are sick. It's just that I don't want my niece to be a widow in a few months."

He said it just like that, to my face. Just like that, he's telling me I'm going to die.

I told him: "But people live for years on dialysis." I was so upset. I kept thinking, if only God let me get married and blessed me with a son or daughter. But I've gotten used to my situation now. It's all

over. *Alhamdulillah* [All praise is due to God], I come to [the hospital for dialysis], I pray, I know God, I have to bring myself above this kind of hurtful talk [*akabbar damaghi*] so that these things won't bother me and so that I can go on.

The doctors, too, told my family that it wouldn't work for someone like me to get married. I don't understand this. My family felt bad, saying that I was only 28 and that I shouldn't hear things like that, so they didn't tell me. But I am not convinced by any of this. Look, there are people here who have been doing dialysis for years and they are married. So why are they telling me that I cannot get married? Only God knows.

Muhammad had his whole life in front of him and suddenly saw it cut short. His difficulty in managing his disease was not only his physical pain and newly acquired disabilities. He told me that the most difficult change to endure had been the ways that his illness had altered his social relationships: his inability to get married, to continue working, and to spend time with friends who fear his condition could be contagious. His physicians had stated that he could not get married, essentially issuing him a poor prognosis, which to him felt like a death sentence. Upon my questioning, the doctors later explained to me that yes, they do indeed discourage patients such as Muhammad from getting married, because the physical and sexual side effects of kidney failure and dialysis would render such a marriage "not viable."¹¹ Shaking his head gravely, Dr. Yusuf had told me that dialysis was not really treatment, and that transplantation was the only way out of this situation. At the same time, Dr. Yusuf had also told me about his own personal misgivings about transplantation, and had questioned whether it was ethically responsible to put a living donor at such an unacceptable risk.¹² He also, like Muhammad, questioned its efficacy for the recipient.

Muhammad described his dialysis sessions, in contrast, as safe: the outcome knowable and his life made bearable. He told me:

Getting a transplant isn't guaranteed. I know my kidney is ruined, so I come to [do dialysis] three days a week. Only God knows if I tried to get a transplant if I would die doing it. There are people who get sick with the transplant, the body rejects it, or they end up with

other diseases. So I need to just be content with what I have. If I tried to transplant, I could die the next morning. So what would I have gotten out of it, just having had myself opened up and stitched back together? Sometimes the operation can last five to six hours—only God knows what could happen during that time.

So I need to stick with what is guaranteed. I come here [to dialysis] and can go home after four hours. And that's it.

This is a trial from God, most exalted and high. He created me as His servant/slave (*'abd*) and out of all the people that He created, God is thinking of *me*, in giving me this disease. And in my suffering, I am getting rid of my sins. I will still be tried [for my deeds after death] but the punishment will be lesser.

I have kidney failure now and could die in five years. Why me specifically—God has ultimate wisdom (*hikma*) in this, it didn't just come to anyone. It came to me, God is saving me [from my sins and heedlessness] because now I remember God all the time. A person has to have his beliefs.

Pain and suffering are not merely objective realities external to and constraining of the self (Asad 2003). Pain can be constitutive of the type of self a person strives to be; it can be transformative, acting on social relationships as well as on the self (Asad 2003). Muhammad worked upon himself through his pain to cultivate dispositions that he saw were righteous and that would prepare him for his final day of meeting God. For Muhammad and his fellow dialysis patients, pain was not an abhorrence to be eliminated at all costs. Indeed, some pain was regarded as a blessing, as a reminder of God, and as something for which to be thankful.

The belief in God's ultimate mercy and the purpose of his suffering, on Muhammad's part, was not an automatic result of having been born Muslim. His convictions were not a fixed aspect of his person—in fact, he admits that he was not particularly religious before his illness, and that he did not previously think of himself primarily as a servant/slave of God. It was through his illness that he came to appreciate, and to an extent, to embody authoritative Islamic discourses that give meaning to his suffering. But this disposition was not one that he had achieved once and for all, that would hence-

forth make his illness tolerable. Every day posed challenges, and it continued to be difficult to get from one day to the next. He talked about how he must constantly and continually work upon himself, through constant prayer, reflection, and invocation (*dhikr*), to come to this sentiment when faced with suffering, treatment complications, and social stigma. Patients would sometimes take turns: when one person lapsed and called out to God to end their misery, another would reassure him and remind him that he was gaining great spiritual rewards for his steadfastness (*sabr*) in a time of trial. The spiritual struggle was never-ending and despair was never far away.

Quest for the Good

Across town, in another hospital dialysis unit, stories of death and disease after transplantation circulated among patients. These stories served as reminders that only God could will life and death. Many patients often repeated that a person could not “save” someone or “lengthen a life” by donating an organ to someone else. Ali, a young patient in the unit, often said that you might think doctors can help—but if they can heal, they are only instruments of God’s unique healing abilities. According to Ali, you might borrow large sums of money to pay a donor to part with his kidney, but you are self-deceived if you think that this will guarantee your recovery. God is the sole guarantor who heals whomever He wills and the One who decides who will die when.

Ali once said to me, “What is that particle that Zewail discovered? A femto-son? We are less than a femto-son in God’s creation!” Ali, like many literate Egyptians, knew well the accomplishments of Egyptian-American Nobel Prize Laureate and chemist Ahmed Zewail and his “discovery”¹³ of the sub-atomic femto-second (which Ali pronounced as “femto-son” in Egyptian Arabic) has entered into the Egyptian lexicon. Ali said this to me after I showed him the back of my American driver’s license where I was asked to be an organ donor after death. Ali did not approve of organ transplantation even from dead donors. Echoing the justification of many Islamic scholars, most notably the popular Egyptian television figure Shaykh Sha’rawi, Ali argued that God alone owns everything including human bodies and their parts. Who are we then to give something away that we do not own? Ali further stated that whoever thinks they are “saving” someone by doing this is presumptuous, as they are less than a sub-atomic particle when compared to divine powers, and God is the only one who saves.

In the hospital dialysis center, Ali remained the most outspoken opponent of the idea of organ transplantation—for himself, that is. He never discouraged others. But Ali genuinely struggled against this idea as something that would improve his own situation.

Ali and his young wife had two small children—the youngest born, he told me, after he fell ill. Unlike the other patients who many times seemed completely exhausted by the dialysis, Ali could successfully fight off the exhaustion, keeping up his energy, and making everyone in his session laugh. Ali and his family lived in the countryside in Minufiyya.¹⁴ Ali had worked in the army, which is why he had the insurance to cover his treatment. Aside from his good humor, Ali stood out in his politicized form of Muslim identity. The other patients poked fun at his full beard, joking that he would be mistaken for a “terrorist,” especially in my “American research.” Ali tended to talk animatedly about the current attack on the *umma* (Muslim community) and about the ways in which we must come closer to God to regain political and moral strength.

Knowing that my topic was focused on transplants, Ali spent many hours with me debating the Islamic stance on donating and receiving body parts. Ali was one of the few patients in the ward who could in practical terms undergo a transplant without too much financial hardship: his wife and his many siblings had repeatedly offered to donate their kidneys to him, and his army insurance would cover all costs of the operation in Cairo. Yet Ali was convinced that this was *haram* (forbidden/sinful).

Ali and I continued for months discussing his situation. One day he told me, “Religion is the only issue that is stopping me.¹⁵ Most people in my situation would say it is *halal* [permissible], because they need it. It is very rare to find someone like me who needs it and still says it is haram.”

I asked him, “Why are you not convinced by the *shuyukh* (Islamic scholars) who say it is *halal*?”

He answered: “I have nothing to do with them” (*malish da’wa bihum*). Ali asked me to read him what I had written so far. After I did, he nodded and continued, “Write this down: If I got a transplant, I would have to pay *no money*. My wife wants to give me her kidney, and the army will pay for it, and they say that I will get experts from abroad [to perform the operation]. But I am convinced: No.”

The army and other employer insurances calculated that the costs of transplantation would be less than years of dialysis treatment, and many encouraged the (ex-)employees whose treatment they paid for to seek

transplantation. I asked Ali why he was so convinced not to pursue a transplant, and Ali told me that God did not make it easy for him to accept the idea. I told him, “But you wouldn’t have to pay any money, and your wife has offered to give you a kidney. Why isn’t this [evidence that] God has made it easy for you?” Ali shook his head and said, “No, but I prayed *salat al-istikhara*.”

He pulled out a wrinkled piece of paper that he carried in his wallet. He told me: “Look at the date.”

The date on the piece of paper was over a year old: April 26, 2002. It was a referral from the army for a fully paid appointment for Ali’s wife to be tissue-typed with him. Ali’s wife had been pleading with him to go to the appointment, but Ali had been refusing, feeling that it was not right.

The Arabic word *istikhara* means “seeking the good.” Many Muslims, when faced with a choice that they feel they cannot make, perform a special *salat* (ritual prayer) of two *raka’* (prayer cycles) in length, and then ask God directly for proper guidance so that they can make the choice that will be good for them in life and in faith. In Egypt, Muslims often pray *salat al-istikhara* before a marriage choice. They believe that your heart must be neutral, that you cannot be leaning toward one decision or another, and that you must truly be committed to doing what is right. God will then answer by making apparent the right choice.

Ali told me that after praying *salat al-istikhara*, he never felt “happy” about a decision to go and get tested for tissue typing. He told me that he did not feel like the right thing for him to do was to get up and get dressed and say to his wife, “Let’s bring the kids and go get tested now.” I asked him, perhaps too cynically, if he felt this way about going to the dialysis unit three times a week. Defiant, he said yes. Ali explained that he interpreted his reluctance to tissue-typing to be God’s answer to his prayer, and refused the idea of transplantation for the past five years, out of fear that it was haram.

Having articulated a deep mistrust of state-appointed Islamic scholars, those who described the practice as “permissible” on state television and in the newspapers, Ali felt that he had only his own heart and conscience to trust. That is why he was deeply committed to seeking God’s counsel through prayer. When he looked in his heart, he did not find transplant as an option that would bring “the good” (*al-khayr*).

A Change of Heart

Ali spent hours debating with himself, and with me, about why kidney transplantation could not possibly be pleasing to God. He would tell me, “God is trying me with this disease. When we are tried by God, we remember Him and praise Him for everything. God says: ‘He who is not pleased with My will can find another universe [besides the one God created] to live in.’”

That is why it surprised me when one day I came to the unit and Ali happily announced to me that he was going to get a transplant. I asked him what had changed his mind. He had gone to Cairo to the military hospital for a check-up and the doctor who treated him there himself had a transplant operation in the United States. He encouraged Ali, telling him that God had given us our bodies as a trust (*amana*) and that he was therefore responsible to take care of it. Dialysis was slowly ruining his body, the doctor told him, and was not a treatment that would ever make him better. But, the doctor reasoned, God blessed him with the *chance* to have a transplant and the military insurance that could cover it. When I had previously spoken to Ali, he would tell me that his wife had pleaded with him daily for her to give him her kidney, but that he refused completely, not wanting to hurt her in any way. But his recent doctor’s appointment had clearly made an impression on him. Furthermore, he said, one of the patient’s sons in his dialysis unit, a military Captain, had heard a television program where a respected Islamic scholar said that it was not haram to have this procedure done, and that God urges us to seek cures. The scholars on television had said that it was haram to leave your body to deteriorate, Ali explained, (*ma ta’adish nafsak lil tahluka*), paraphrasing the Qur’anic verse in colloquial Egyptian Arabic.

Ali was happy and laughing that day, saying “May God stand by us.” He said that when he was in the Ma’adi hospital, he spoke to a lot of doctors and that they said that they performed transplant operations there every day, and that the outcomes were successful. People did fine after transplants, they told Ali.

Ali told his wife, Wafiyya, to come to the unit that day so that I could speak with her as well. As we passed by him to go to the waiting room, he winked and gave her a high-five. Wafiyya and Ali, both 28 years old, had been married for seven years and had two young children. Wafiyya’s situation illustrates the ways in which kinship patterns shape the ethics of organ transplantation in Egypt. Wafiyya told me:

Before, Ali kept saying that it was haram, and also he was worried about me, because of the children. From the beginning of his sickness, I've been begging him to transplant. Dr. Charles, also for the past two to three years has been telling him that he's young and that the disease will hurt him.¹⁶

But he kept saying that transplanting was haram. Back when we got the *qirar* [authorization for state medical coverage] to be able to do the tests, we were on the path to getting this transplant done, and all of a sudden he said: "No." But now he's starting to accept the idea again...

I heard [the popular television religious figure] Shaykh Sha'rawi say that God gave [your body] to you, and you can't give away what God gave you. But I said [to Ali]: Why can't I give it to you? I'm going to save you. Am I supposed to leave him and let him die? But he kept saying no, because of the children.

Back then, our daughter was 3 and a half years old and the boy was just three or four months old. Now the girl is six and the boy is 4. But I'm still worried about them (She starts to cry). Right now they are in a nursery—where will I leave them? Who will look after them? His brothers and sisters say, "[We'll donate], leave your wife. She's so young." I went and talked to my parents. I told them: "This is my life and he's my husband, and if God forbid, something happens to him, what am I going to do?" (She starts to cry again.)

Wafiyya's parents felt that they had to protect her at all costs. What went unstated was that Ali could soon die, and her parents worried about her being in a vulnerable physical and social situation that could be exacerbated by the loss of her own kidney. But her main concern was for her husband to get better so that their family life could continue. Ali's siblings felt bad letting Wafiyya be the one to donate, but if they were to donate, Ali would have to worry about his siblings' spouses' feelings.¹⁷ Wafiyya continued:

Yesterday, the army doctor in Cairo said to him: "It's been five years on dialysis. That's enough." The doctor's wife had given him her kidney, but [they performed the operation] in the United States.

So Ali said to himself, “When you keep washing your *galabiyya* [long dress-shirt] it starts to tear, and it wears out. Dialysis is like that, washing the kidney and wearing it out. After five or six years it will be completely worn out.”

The body is the same way. He is making *jihad* [struggling to get better] on his whole heart, on his whole body.

Wafiyya was obviously torn over the position she was in. At least when Ali had refused to even consider a transplant, on the grounds that it was haram, she had given up feeling responsible. Now, she said:

I just want him to transplant so that he gets better, and so that he can get back to his normal self. But he says that he doesn’t believe that transplanting will get him back to normal.¹⁸ I tell him: “Our Lord is with us” (*Rabbina mawgud*).

Ali and Wafiyya did eventually decide to return to the Cairo military hospital laboratory for tissue analysis.¹⁹ A few weeks later, I was back at the dialysis center when Ali got a phone call in the unit. I could see Ali’s face clearly while he was on the phone.

It was from Wafiyya and she had just gotten the results of the lab back. Ali tried to act calm and unaffected: “Wafiyya heard from the [military] hospital. Let’s see what will happen now,” he announced to a fellow patient, Madame Sabah, before returning to Wafiyya on the phone.

There was no tissue match.

Ali still sounded unimpressed saying, “Okay, okay, Madame Sabah sends her *salamat* [greetings] to you,” and hung up, announcing to whoever was interested that there was no match.²⁰

Madame Sabah immediately saw through Ali’s attempts to be cavalier about the news. She said: “Don’t be upset, Ali, we’re better off this way. We won’t make other people [i.e. the donor] sick with us, we won’t get all swollen [from the post-operative treatment], we won’t be in the hospital days after days, worrying about some kind of infection. The way we are with dialysis is just better.”

Madame Sabah was a widow in her fifties who never had any children. She was so pleasant and well-loved that she had many family members who offered to donate their organs to her, most pressingly her

niece. But there was no way Madame Sabah could think of taking this from her. Mothers generally refuse to take kidneys from their daughters; the unstated presumption was that life should flow from older to younger generations. In this logic, who is a mere aunt to accept a kidney from her niece?

Later, Ali told me, “Madame Sabah was just saying those things to make us both feel better, so that we would be able to stay patient and steadfast in the face of this hardship (*tasabbar nafsaha wa tasabbarni*). But of course she wants a transplant and to get better, just like the rest of us. But what can we do?”

In the months that followed, Ali came to accept this news as a gift from God. God had prevented him, he explained, from doing something potentially haram. He continued to thank God for the blessings that he was receiving on dialysis. A year later, the patients in the dialysis unit were cheered up by the news that Ali’s wife Wafiyya gave birth to another baby girl, whom Ali described as “sweet as honey.”

The hours that I spent talking with Ali made me appreciate more fully the complex ways in which people embody and live questions about divine will and how much of their lives they feel they can control, and how much they feel they *should* control. In contrast to the US situation, where kidney-failure patients could be put on a waiting-list to receive kidneys from anonymous brain-dead donors, in Egypt, patients had to “find kidneys” themselves, from living donors.²¹ It was clear that in the Egyptian case, patients themselves having to find their own kidney for transplant brought to the surface a host of ethical questions and dilemmas.²²

Once, in trying to compare Ali’s situation with that of patients in the US, I asked Ali what he would do if he could hypothetically put his name on a list and be told that the hospital would make all the arrangements for him to receive a kidney from an anonymous dead donor. He thought for a while and said that he would probably accept it, even if deep down inside he still had reservations.

A remarkably insightful man, Ali realized that his refusal was shaped and instantiated in a particular social situation in which he had to overcome several obstacles to proceed with a transplant (to find a donor, to be responsible for the donor’s tests, to bear the responsibility for the donor’s sacrifice, pain, and side effects). Already predisposed to mistrust this particular medical practice, Ali lacked the drive to surmount each hurdle, as each of these steps continuously raised for him the ethical uncertainties

surrounding organ transplantation. He thus recognized that were he in an alternate socio-medical setting in which a kidney was somehow made available to him without such constant reminders, he would likely accept it. Given the reality he lived in, though, he turned to God to seek the strength that he needed to remain on dialysis for the rest of his life.

In explaining Ali's reluctance to pursue transplantation from his wife in his first five years on dialysis, his physicians described him as "religiously extreme" or "fatalistic." But Ali himself did not think of his religion as preventing him from seeking a beneficial treatment. Nor was his reluctance the default position due to scarce material resources inhibiting medical access. Ali did have military insurance that could cover all the costs of a transplant, and family members willing to donate to him. Yet he insisted that he would rather die and "meet God" than be responsible for causing harm to his family members, or for putting his family in debt to buy a (tissue-compatible) kidney, which he saw as clearly haram.²³ Ali harbored deep reservations about "using" his wife as his kidney donor—being responsible for his wife's potential illness, suffering, or potential inability to look after their children.²⁴

But what are we to make of Ali's sudden change of heart? He had temporarily allowed himself to be convinced by a competing moral discourse about the meaning of the "body belonging to God," in which he should pursue transplantation as a means to respect and care for the body that God had given him. And what are we then to understand of Ali's ultimate acceptance of the news of incomplete tissue match as a divine sign to not pursue the transplant?

The doctor at the military hospital, and hearsay from a fellow patient's son about the proclamations of a television *shaykh* (of the type Ali had earlier claimed not to trust) were in one instance able to convince Ali that it was part of his religious duty to pursue transplantation to protect the body as a divine trust. This occurred in a new context in which Ali was shown the fruits of successful transplant surgeries and the routinization of transplantation in a large military hospital in Cairo. While his thrice-weekly routine of hemo-dialysis in a less-than-ideal hospital setting in Tanta had made him wary of medical services and practices, the state-of-the-art facilities in Cairo had made an altogether different impression on him, particularly the doctor's exhortations that such potentially efficacious treatment (the doctor himself having been a post-transplant survivor returning to daily activities) were within his reach.

Perhaps it was returning to the reality of poverty in his rural village in Minufiyya that deflated his hopes. Or perhaps it was his return to the drudgery of the commute to Tanta and the dialysis regimen. When a slim window of hope had opened and transplantation looked like it might be a beneficial solution to his illness, Ali saw it as not only religiously permissible, but agreed with the doctor that it would be a religious *duty* to pursue it, if it meant restoring his health. But this hope was fragile, and was soon crushed with the news of an incompatible tissue match with his wife.

Patients like Ali who at times seemed the most resolute in their positions often change their minds depending on changing circumstances in their lives. This does not make their religious convictions any less strong or meaningful. Finding it hard to believe the religious scholars who permitted transplantation, and long unable to make this position salient in a situation in which he might harm his young wife, Ali had initially turned to supplication and prayer for guidance. Many analysts of religion, appealing to notions of false consciousness, would maintain that such behaviors are examples of religion serving as a “comfort mechanism” in suffering. In Egypt, some physicians and interlocutors I encountered would interpret the fact that Ali had believed that transplantation was permissible when his wife was still potentially a donor for him, and later as forbidden/sinful when his wife’s tissues were not a match, to be a manipulation of the religion to suit his circumstances.

But such an interpretation would miss the point. Religion was not an object external to Ali’s self that he manipulated to suit his needs. Devout patients like Ali embodied a religious tradition in which they struggled to cultivate within themselves the disposition of *rida*, or contentment with God’s will. Ali believed strongly that true submission to God maintains that God’s will transcends everything, and the purpose of worship and remembrance is to bring oneself in utter closeness to God, such that “God is with you wherever you are” (The Qur’an, *al-Hadid*, 57:4), and “Wheresoever you turn, there is the Face of God” (The Qur’an, *al-Baqara*, 2:115). That is to say, in Ali’s devotion to God, when he felt that he had the opportunity for transplantation, he felt that God had willed for him to seize this opportunity. When there was no such potential, after news of his wife’s incompatible tissue type, he read God’s will favorably as well: that God had prevented him from pursuing something potentially harmful or sinful.

In the words of an oft-cited Prophetic tradition, “How remarkable is the case of the believer! There is good for him in everything, but this is not the

case for anyone except for the believer. When the believer receives any good, he is thankful to God, and gets a reward. And when some misfortune befalls him, he endures it patiently, for which he is (also) rewarded.”²⁵ As Ali and many patients re-iterated, the Prophet Muhammad indeed told his believers to “seek counsel (*fatwa*) from their own hearts.” This had led many to the conviction that behind their specific illnesses lay divine wisdom. In these specific struggles toward God and conscientious development of dispositions of fortitude, they embodied the sentiment that their bodies belong to God and remained preparing for the day that to God they would return.

One day when sitting with a group of patients’ wives and mothers in the dialysis waiting room, I heard them discuss the possible causes of kidney failure. They wondered whether their loved ones were predisposed because of previous infections with schistosomiasis, whether it was the toxic water or air or whether it was the pesticides in the food.²⁶ One woman then forcefully cut the conversation short: “No, this comes from God,” she said. The patients nodded and the conversation shifted. This reiteration was a reminder that God’s infinite wisdom is behind all trials. It was also a call for the proper disposition toward illness. To blame the environment for high levels of toxicity when one feels ultimately helpless against it fosters frustration and anger, rather than the proper sensibility of steadfastness, fortitude, and ultimate gratefulness toward God.²⁷ God’s will, in this worldview, is never deemed “senseless.”²⁸ Dialysis patients who cried out in pain were gently told by fellow patients or family members to glorify God instead.

Through ethical dispositions toward steadfastness and patience, many ill patients drew on Islamic theological notions of faith in the face of suffering as redemptive of past sins or heedlessness of God. Some patients lamented that they could not perform the pilgrimage to Mecca due to their dialysis treatment, and some of them debated amongst themselves whether they could try to make the trip anyway, given that Saudi Arabia has dialysis centers available. One of the patients in the center had discovered that he had acute renal failure when he fell into a coma while performing the *hajj* in Mecca. He was taken to a hospital and put on dialysis for months until he was well enough to come home. He had later remarked how grateful he was for the fact that the Saudi government had funded such treatment and made it available to those in the country for pilgrimage. This story had made other patients consider embarking on the journey. It was not that they saw it as an obligation that they must fulfill; it was clear to them that in their states of illness they were exempt from this duty. They envisioned the *hajj* as a sub-

lime spiritual experience that would re-charge them with the fortitude and faith required to go on. Here again, steadfastness is not a “passive” disposition, but one that requires a training of the senses through acts of piety, such as ritual prayer, reflection, invocation of God, or pilgrimage.

Conclusion

In Western academia, there has been much discussion of Muslims as “passive fatalists” on the one hand, and attempts to show that this is not the case—that Muslims really do have “agency,” on the other. Yet this debate has missed the more important questions of *how* such a disposition (what I have called the reliance on and acceptance of God’s will) is achieved, and under what contexts. Many patients with whom I worked in Egypt conscientiously and rigorously trained themselves to regard all acts as products of God’s perfect wisdom and ultimate will (Asad 2003; Mahmood 2005). Many lamented that they fell short of the religious virtue that they sought to attain. True faith, as they saw it, is accompanied by *tawakkul*, a disposition that must be continuously cultivated through pious practice and reflection. It is only through constant prayer and strong belief, they often told me, that they could endure their trials.

Whereas the disposition of forbearance can clearly provide great social and psychological relief to the patient, this does not mean that patients manipulate religious sentiments to maximize this benefit from it. One tendency in Western scholarship is to view the cultivation of steadfastness as passive, and another is to view it as an active manipulation of the religion to serve as a comfort mechanism, or to placate the disadvantaged (Sholkamy 2004). We should not assume that patients foreclose all treatment options out of “fatalism,” nor should we assume that they merely appeal to God to comfort themselves, after the fact, in their lack of access to treatment.²⁹ People embody and experience religions to varying effects. In the case of Ali, his efforts to cultivate steadfastness as he struggled to “find the good path” involved a continual alignment of himself with God’s will. He continually invoked God to allow him to understand each turn of event as part of God’s overall plan of benevolence and compassion (*al-rahma*).

To assume that religious practitioners refuse particular technologies or medical interventions out of “fatalism” carries the danger of missing the contingencies that inform when and under what conditions patients work to achieve this disposition. Such a characterization potentially overlooks

rampant problems in medical care which patients seek to avoid. Paul Farmer has memorably cautioned against the tendency to confuse structural violence, poverty and inequality with “cultural difference” (Farmer 1992, 1997, 1999). I would add that there is also a tendency to conflate poverty and structural violence with “fatalism”—a tendency which obscures possible problems with treatment as well as the ways in which forbearance is a virtue that can be actively cultivated in coping with suffering, rather than a direct outcome or cause of suffering.

The perceived efficacy of a treatment plays an important role in shaping an ethical stance toward it. To understand complex ethical decisions, we must be attentive and vigilant to patients’ own experiences and understandings of their disease processes and etiology, and their own cost-benefit analyses which may be articulated in religious terms. That said, we should not assume that patients appeal to God’s will *only* because a treatment has been deemed inefficacious or inaccessible. In many cases, the ethical disposition patients have toward a particular treatment, an assessment of its benefit and harms, as well as understandings of disease etiology and specific experiences of the illness are not separate from, nor do they formulaically determine, various dispositions toward divine will and acceptance.³⁰

I have argued in this article that religious sentiments, including those that attribute a positive value to steadfastness in suffering, should not be seen as passive, as anti-science, or as constraints to medical treatment. In various ways, patients grappled with how to achieve the most benefit for themselves and their families while trying to conform to what would please God. Reliance on God should not be understood in opposition to seeking treatment—that is, we should not ask whether patients appeal to God *or* seek treatment, for one does not necessarily exclude the other. Rather, we should remain attentive to the interrelations between the two. An appreciation for what it means to embody a religious tradition, in which religious reasoning and sentiment is not understood as external to the self, but as *central* to it, can help us broaden our understanding of medical life-and-death decisions and of ethical formations in devout patients’ lives.

ACKNOWLEDGMENTS

Thanks to Mazyar Lotfalian and Christopher Furlow for their invitation to submit to this special issue. I benefited from the discussion of Michael Fischer at the AAA panel on “Islam and Science” in December 2006, and from feedback on previous drafts of this

piece from Ian Straughn, Jessaca Leinaweaver, Zareena Grewal, and two anonymous reviewers for AQ. Thanks also to Richard Grinker, AQ editor.

NOTE ON TRANSLITERATION

I have simplified standard IJMES transliteration from Arabic to English. I have omitted the ‘ayn in front of Ali because ‘Ali’s in possessive form appears cumbersome. I have also omitted the definite particle in proper place names (Gharbiyya rather than al-Gharbiyya, Minufiyya rather than al-Minufiyya).

ENDONTES

¹Fatalism, the notion that humans can exert little or no control over their own destinies, has long held the fascination of Western social theorists. For example, Durkheim (1979[1897]) argued that fatalistic tendencies resulted from structural forces in society that coerced individuals into feelings of utter hopelessness. Weber’s comparative study of religion focused on the cosmological forces that shaped fatalistic worldviews (2003[1904]). Weber specifically turned to Islam and Hinduism as cases to contrast with the purportedly more logical and rational notions of predestination that were central to Protestant theology and from which emerged modern capitalism. See Nafissi 1998 and Acevedo 2008 for a discussion. According to the French Marxist historian Maxime Rodinson, Weber did more than anyone to establish the view that Islamic “fatalism” is responsible for the stagnation of Muslim societies and the “listlessness” of Muslims (cited in Nafissi 1998:107).

²This assumption forms the premise of Samuel Huntington’s and others’ “Clash of Civilizations” thesis that argues that the cultural division between the Judeo-Christian West (in which an ethic of individual self-empowerment prevails) and Islam (in which Muslims are condemned to fatalism, authoritarianism, and the inability to evolve) will dominate the global political scene of the 21st century (Huntington 1993, 1996; see Acevedo 2008 for a discussion).

³Hence the particular European narrative of science and technology emerging in opposition to religion is assumed to be universal. Another false assumption is that science and technology necessarily lead to social benefit for all.

⁴Such debates surface in centuries-old debates of Islamic thought, whether under the rubric of *kalam* (theological debates), *‘aqida* (doctrine), or *fiqh* (jurisprudence). Varying conceptualizations of human behavior, between the poles of *tawakkul* (utter reliance on God’s will) on the one hand and *sa’i* (acting in this world) on the other have parallels to, but are not the same as, longstanding philosophical and theological debates between *irada* (human agency) and *qadar Allah* (the predestination of God’s ultimate will).

⁵The legitimacy of viewing God’s predestination of all events as negating human agency and human responsibility (*al-istislam al-qadari*) has been refuted by Islamic scholars. However, I would argue that contemporary Muslims, including nationalists and physicians, look down on *tawakkul* (which is highly valued in the Islamic scholarly tradition) as also being “anti-science” and anti-progress (as do Western observers) and bolster their arguments with Islamic scholarly discourse against *al-istislam al-qadari*. In Western academia, I believe that the word “fatalistic” has been used to describe dispositions that might be variously called *sabr*, *tawakkul*, or *al-istislam al-qadari*.

⁶Muslim reformers such as Muhammad ‘Abduh, Rashid Rida, and Jamal al-Din al-Afghani re-oriented discussions of correct Muslim behavior in terms of active responsibility and social progress, specifically arguing that the active pursuit of scientific knowledge was a

duty incumbent upon Muslims (Keddie 1972, Hourani 1962, Kerr 1966, Dallal 2000, Rahnama 1994).

⁷The Egyptian fellah, or peasant, was said to be particularly prone to submissiveness and fatalism, a disposition that observers used to explain the continued oppression of Egyptians and their supposed aversion to revolt. Historian Gabriel Baer discusses how misleading this generalization is and on what shaky grounds it stands; see Baer 1969, chapter 6. For a humorous and insightful discussion of Ayrout's depiction of the fatalistic Egyptian peasant, and its continued appearance and persistent influence among "experts" on Egypt, see Mitchell 2002.

⁸Important exceptions to this lacuna are discussions by Asad 1993, Asad 2003, Mahmood 2005, Hirschkind 2006.

⁹Tanta is the capital of the Nile Delta province Gharbiyya, located less than 100 km north of Cairo. I conducted fieldwork in five different private and public dialysis centers there. I omit the full names of patients and physicians to protect their privacy. All interviews were conducted in colloquial Egyptian Arabic.

¹⁰Although the poor receive government compensation for dialysis, this does not mean that all poor patients in need of dialysis receive it. Major obstacles include high rates of under-diagnosis of kidney failure, the lack of access to dialysis clinics, and the lack of know-how to obtain the necessary paperwork from the government for compensation.

¹¹This illustrates the ways in which physicians in Egypt act as social gatekeepers. In this instance, the physicians did not confine their role to intervening in the health of Muhammad, their patient, but also intervened in the larger social consequences of his family, including of a potential wife.

¹²As I lay out in my larger study on organ transplantation in Egypt, the lack of agreement over the legality of extracting organs from brain-dead patients means that transplantation (of the kidney and liver lobe) depend entirely on living donors. See Hamdy 2006.

¹³For discussions on whether sub-atomic particles are "discovered" or "constructed," see Andrew Pickering (1984) and Ian Hacking (1999).

¹⁴Minufiyya is a rural province in the Nile Delta, from which Ali commutes to Tanta thrice-weekly for his dialysis treatment.

¹⁵Armando Salvatore (1997) discusses what he calls the hyper-objectification of Islam among both Western observers and contemporary Muslims who draw on Islamic rhetoric for political ends. Ali, in his politicized form of Muslim identity, stands out from the other patients (many from rural backgrounds) when he makes statements such as "Religion is the only thing stopping me." Most of his fellow patients do not articulate "religion" as an autonomous agent in this way. I argue in the paper that Ali does not generally view "religion" as an object external to himself, but in the above quote he is participating in an increasingly dominant discourse that represents the role of religion in one's life in this objectified way.

¹⁶Dr. Charles was a British nephrologist who oversaw the dialysis clinic in Tanta.

¹⁷See Hamdy 2006 for a discussion of how kidney donation flows along specific kinship patterns, with respect to age, gender, and family position.

¹⁸See Crowley-Matoka 2005 on Mexican post-transplant patients' sense of liminality between illness and recovery, and how they never quite achieve the promise of returning to "normal."

¹⁹Crowley-Matoka notes that much unlike the situation in the U.S., in Mexico (and, I would add, in Egypt as well) it is the medical professionals who create the desire and demand for kidney transplantation among patients (2005).

²⁰The more powerful generation of immunosuppressant drugs that are now available in Egypt (at higher cost) make complete tissue match less necessary, and many in Ali's position might have proceeded with the transplant anyway. In this case, refusal to proceed was both a combination of reluctance on the part of Ali and on the part of the physicians. Because the number of patients needing transplants far exceeds the facilities available, physicians in Egypt (in state hospitals) are disinclined to proceed with transplants without a full tissue-match, to increase chances of graft survival. See Cohen 2001 on the relationship between donating kin and immunosuppressant drugs.

²¹The process is much more mystified in the contemporary U.S., where kidneys are procured through a complex medical industry, the minutia of procurement rendered less visible to the waiting patients. This is especially the case with organs procured from brain-dead patients. Yet living kidney donation is currently on the rise in the U.S., exceeding cadaver donation for the first time in the U.S. in 2001. (Kaufman et. al. 2006:82).

²²Crowley-Matoka argues that with each step (finding a kidney, testing, paperwork, etc.) desire for the transplant is created and substantiated in the patient (2005). Ali's case also shows that with each step, a patient's hopes can be quickly dashed. North American kidney-failure patients also face these dilemmas of finding their own kidneys, when they feel that the waiting-lists are too long and that they cannot sustain life on dialysis while waiting (see Kaufman et al. 2006).

²³While the buying and selling of organs is officially illegal in Egypt, hospital regulations generally turn a blind eye to the practice which has proliferated in Cairo, and hospital laboratories often facilitate tissue-compatible donors willing to sell their kidneys with potential recipients.

²⁴I argue elsewhere that wives' bodies are generally seen as more "expendable" than those of men, and that wives generally donate kidneys to their husbands at much higher rates than the other way around (Hamdy 2006).

²⁵This hadith is well-known and oft-cited among Egyptians. It is cited in the modern Islamic scholar Sayyid Sabiq's compendia of hadith traditions, *Fiqh al-Sunna* (Sabiq 1994).

²⁶See Hamdy 2008 for the ways in which poor Egyptian dialysis patients posit what I call "political etiologies" for their kidney failure which renders the logics of transplantation nonsensical. I argue that poor Egyptian kidney-failure patients understand and experience their illness in terms of Egypt's larger social, economic, and political ills, implicating corrupt institutions, polluted water, the mismanagement of toxic waste, and unsafe food. Transplantation is thus understood to be a medical treatment whose potential benefits cannot possibly surmount the harm done to their bodies, nor do the benefits seem to outweigh the costs.

²⁷In contrast, recognition of the cause of injustice and suffering and doing something about it, if one was able, is viewed positively in Islam, as part of "commanding the good and forbidding the wrong" (see Cook 2003 and Mahmood 2005).

²⁸This is an important point because scholars of organ transplantation in North America argue that a major incentive for surviving family members to agree to the donation of their loved ones' organs is to construct meaning out of the "senseless" loss of life (Lock 2002, Sharp 2006).

²⁹Hence my slight difference from Hania Sholkamy's important discussion of forbearance in Egyptian medical experiences, where she writes: "God, as the ultimate source, is a formula that helps *ex post facto* acceptance but is not one which precipitates an *a priori* fatalism. It is a tenet that leaves plenty of room for people to take initiative in defining, managing, and protecting their health and well-being" (Sholkamy 2004:122). For Ali, what was important was a *continual* alignment of himself, and his own desires, with what he understood to be God's will.

³⁰For example, artificial insemination with donor sperm is rejected as a treatment for male infertility, but not because it is seen as inefficacious or inaccessible. Infertile couples in Egypt appeal to God in cultivating steadfastness in their difficult situations rather than resort to practices that rely on third-party semen, ova, or wombs, for they consider these practices to be unethical for introducing foreign reproductive elements into a marriage and “confusing” the blood lineage of the offspring. These practices, notably, do not achieve the desired goal, which is defined as producing biological offspring of both husband and wife (Hamdy 1998; Inhorn 1996, 2003).

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