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The American University in Cairo

School of Humanities and Social Sciences

Tomorrow's Doctors and Today's Changes: Neo-liberal Discourses and the Daily Practices of medical Interns at a State University Hospital in Cairo

A Thesis Submitted to

The Department of Sociology, Anthropology, Psychology, and Egyptology

In Partial Fulfillment of the Requirements

For the Degree of Master of Arts

In Sociology - Anthropology

By **Salma Shokralla**

Under the supervision of **Dr. Joseph Hill**

May/ 2010

Abstract

Tomorrow's Doctors and Today's Changes is a thesis submitted by Salma Shokralla under the supervision of Dr. Joseph Hill, Dr. Adrienne Pine and Dr. Hanan Sabea, to the Sociology/Anthropology Department at The American University in Cairo (AUC). As the State shifts towards liberalization policies in the health sector, debates surrounding the outcomes of medical encounters came to the core of public debate. To understand changes that are influencing medical encounters and their outcomes, this study focused on the socialization process medical students go through to become practicing physicians. A public university hospital (Al Kasr Al Ainy) where medical students get their practical training was the focus of this study. Courses on physician-patient encounters, newly implemented under the government's education reform plan, were analyzed as an example of how discourses are produced to shift the responsibility of public health from being a state responsibility to becoming an individualized one.

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Introduction

The aim of this research was to understand the changes that are currently taking place in the light of the currently rising neo-liberalist discourses. Neo-liberal changes in the health sector have been witnessed since the early 1980s (Chiffoleau 2005; Ali 1997; Shukrallah) .By neo-liberal I refer to policies, theories, arguments and modes of governing that defend private property rights, free markets, free trade and the privatization of public assets by attacking public services and locating service responsibilities elsewhere, namely on the individual (Sen 2003; Harvey 2005; Sexton 2003). However, the public debate over this change has been most prominent only the past 5 years, and the proposals set forward by the Ministry of Health to privatize the Health Insurance Organizations (HIOs) was one of the main triggers of this debate. Neo-liberalism, on the other hand, has been gaining ground within Egypt ever since the infitah (open door policies) and, as some argue (Chiffoleau 2005; Ali 1997; Shukrallah), some of its rationale has been present in the medical culture even before.

Accumulatively neo-liberalism has been infiltrating the medical field through different channels, state led and private, shaping the medical culture present today. The Ministry of Health's proposal to privatize some of the health services may have triggered the debate over changes in the medical culture and institution but did not produce the changes happening in the health sector. To understand the changes taking place in the health sector, neo-liberalism's effects need examination. Consequently, this research focused on a microcosm of these changes and put it in relation to the policy changes being proposed by the Ministry of Health. The intern life at Al Kasr Al Ainy has been studied as an example of how medical professionals are socialized to become doctors. Through focusing on newly implemented courses on medical ethics that have been applied as part of the national and international accreditation criteria, I discuss one example of

how interns are being taught to take individual responsibility of medical care and expect little support from state institutions as health providers.

As interns are learning to become doctors, neo-liberal discourses form a big part of their learning process. Although interns express their lack of faith in the state education institutions that teach them the courses under study, their acceptance of the neo-liberal discourses, that also shape the content of what they are learning, is fostered by many other influences. Neo-liberal discourses are to a large degree becoming hegemonic within the health service sector. However, interns observe gaps between neo-liberal discourses and their daily realities. Nevertheless, critiques of such gaps are mostly directed to the state institutions that propagate these discourses rather than the neo-liberal overarching rationale. This study shows that the state is increasingly losing its hegemony although the neo-liberal discourses, now defended by some state agents and institutions, are gradually becoming hegemonic. The neo-liberal discourses gain hegemony through different channels, not only those that are state controlled. Moreover, their acceptance is facilitated by the already dominating market and individualist logic that has already been part of the older state discourses that were dominant before the *infitah*.

Neo-liberal discourses, I argue, create what I call here an imaginary. I use imaginary here to refer to the model set forth by these newly dominating discourses that construct a world which the individual enjoys a high level of autonomy and where the socio-economic structures have little influence. The discourses create this imagined world by claiming that individual physicians can accomplish good quality medical services, without state support. In other words, neo-liberal discourses highlight the role of the individual to an extent where it makes it believable that

individuals can accomplish the desired health care service required, despite the socio-economic structures that may hinder individual autonomy.

1 Transformations of the Medical Field in Egypt: Scientific Hegemony, Objectification, and Commodification

The question being addressed in this research namely, how physicians are socialized to produce medical practices under the currently expanding neo-liberal mode of governance, witnessed in Egypt today, has its roots in longer processes of scientific hegemony, objectification and commodification. In other words, to address the question at hand, an understanding of the development of the medical system and profession needs to be present. An analysis is required of the different processes that have shaped and continue to be shaping the medical profession, in addition to an analysis of the processes that are currently shaping debates over health care in Egypt today.

Overall, studies focusing on the development of the Egyptian medical profession and the influences shaping it have pointed out to three main themes. The first is the superior position science and medical knowledge has obtained and the superior position it gave to medical professionals ever since the establishment of modern medicine in Egypt. The second relates to how medical professionals objectify and dehumanize patients throughout their education and practice. The third is the commodification of health, which is argued to have been an aspect of modern medicine ever since British rule in Egypt (early 1900s).

The argument given by Chiffoleau and Shukrallah, is that the medical institution was to a large degree a colonial one (Shukrallah; Chiffoleau 2005). Although modern medical education was not introduced under direct colonialism, it was established by French professionals who used

their position to spread Modern French thought (Sonbol 1991; Mahfouz 1935). Modern French thought refers here to the ideals of enlightenment that put a great emphasis on science and scientific knowledge. From the time modern medical education institutions were introduced they were presented as competitors to local healing institutions and traditions. The first medical school, Al Kasr Al Ainy, sought to create practitioners that were cut off completely from the healing traditions present at the time. Therapeutic institutions such as the *Morastans*, which dated back to Arab rule, as well as healing practices of local barbers were completely rejected by the newly appointed French medical professionals (Mahfouz 1935).

Challenging and undermining all other forms of healing methods entailed that modern medicine in the context of Egypt held its ideology superior to any other form of knowledge that had existed and in opposition to local knowledge. In many contexts other than Egypt, modern science including modern medicine identified itself as the only source of objective knowledge and established itself in opposition to other forms of knowledge or practice. Science as an ideology is particularly powerful because of its claim to objectivity and its claim that it is not an ideology (Habermas 1970). Modern medicine's superior position over other forms of knowledge and practice endowed a class of medical professionals with power, as holders of objective knowledge (Chiffolleau 2005). Shukrallah, in addition, argues that the affiliation of this new class of medical professionals with Europe and European modern thought also gave them a position superior to other locals.

Moreover, science in the form of medicine came with its own concepts and created its own discourse. Michel Foucault wrote in the *Birth of the Clinic* that modern medicine has introduced the 'medical gaze', and for the first time individuals were treated as mere subjects of study,

causing their complete objectification (Foucault 1975). The ability to see through the human body and observe it in the form of separate organs with different functions has led to the individual's objectification and dehumanization. Patients have become objects and "one at last could hold a scientifically structured discourse about an individual" (Foucault 1975, xiv). This way of seeing or the 'medical gaze' was applied to the Egyptian context by the application of modern medicine, through French influence. A book published by three physicians on medicine in Egypt titled "*Sick Medicine*" discussed how by the time medical students in Egypt reach their training years they start seeing patients only in terms of their sickness and not as whole human beings (Sabour, Hassan, and Shaalan, 65)). The patient is only referred to as "the heart failure" or as "the pyloric ulcer", state the authors (Sabour, Hassan, and Shaalan, 64).

Chifolleau has also argued that the making of medical professionals, since the early 1900s, was very much shaped by the introduction of private for profit health care. The introduction of profit oriented health care, created a medical professional class who saw health primarily as a commodity. The concept of health as a profit generating profession was also defended by medical professionals, according to Shukrallah, even when the 1962 constitution tried to introduce health as a right and create a welfare system of health care.

To sum up, the available literature on medical education and the creation of medical professionals points out to three main themes that are encountered when studying the health institution in Egypt. One is the superior position given to medical knowledge and those that carry the knowledge. The second is the de-humanization of patients that has become an integral part of the medical education system. The last theme is the commodification of health that has also become an aspect of modern health care in Egypt. Even though, according to studies

mentioned above, all these factors predominate at present, new factors need to be studied as to how they interact with the making of health professionals. Recently under scrutiny within public debate over health care has been the current government's structural adjustment plan targeting primarily the health and education sectors. Since the 1990s Egypt has endorsed several international agreements explained in detail by El-Eisawy (El-Eisawy 2007). In May and November 1991, two agreements with the IMF and the WB called the "program for Economic Reform and Structural Adjustment" were signed. In these two agreements, the IMF pushed for the removal of price control, freeing exchange rates and cutting down on governmental expenditures for services (including health care services). The WB, on the other hand, pushed for the reformation of the economic structures and services towards cost recovery and for the privatization of public firms (including public health institutions) (El-Eisawy 2007, 88-103).

Harvey argues that through such treaties, as the ones mentioned, developing countries as well as developed have adopted neo-liberalism. "While in developing countries the strategy for adopting neo-liberalism was accomplished by a combination of military intervention and economic treaties, in developed countries it was accomplished by a strong manipulation of culture" (Harvey, 2005). However, in this research I will show that the "manipulation of culture", as Harvey explains it, is gradually becoming part of how neo-liberalism is also being endorsed in Egypt, a "developing" country. By neo-liberalism, Harvey refers to political-economic practices that dedicate states to defend private property rights, free markets, free trade and the privatization of public assets. Such practices are currently being championed in Egypt, partially by the use of the above mentioned treaties and policies but also through different, sometimes even unrelated actors and institutions. .

Globally, many studies discussed the impact of neo-liberalism on health care services and argued that it has changed the structure of health institutions drastically, impacting the services patients receive (Farmer and Rylko-Bauer 2002; Hall 2003; Navarro 1986; Qadeer 2003; Sexton 2003; Sen 2003). Studies that link neo-liberalism to physician practices and, more particularly, focus on the making of practicing physicians repeatedly mention three main themes. The two themes that came up in studies related to physician patient encounters under neo-liberalism include marginalization of patients' concerns and objectification of patients. It is being argued that part of the learning process under such a structure is to learn to ignore or marginalize concerns that may question the status quo, namely neo-liberalist political-economic structures (Waitzkin 1989; Waitzkin 2000). The doctor is taught to focus only on biological aspects of illness, applying the medical gaze. Consequently, doctors tend to fetch for purely biological information, disregarding all other issues and marginalizing the patient's other concerns, even when the patient articulates their importance (Fielding 1995; Waitzkin 1989; Waitzkin and Theron Britt 1989; Waitzkin 1990; Waitzkin et al. 1996; Waitzkin 2000).

The third theme that is often mentioned when speaking of health under neo-liberalism is commodification. Commodification, it is argued, is such an integral part of neo-liberalism that it is applied to all aspects of life, including people's health and their very own lives (Farmer and Rylko-Bauer 2002). Commodification here refers to profit making health care that deals with people's health as a commodity, which people can either afford to pay for or not. Bennett argues that one of the expected outcomes of private health services is that it encourages "unethical behavior on the part of private sector providers in recommending more, and more profitable, interventions which are not medically indicated" (Bennett 1997, 28). In other words, leaving

health to market forces encourages physicians to over-medicalize those who can pay and under-medicalize those who cannot.

Since all these aspects whether objectification, marginalization or commodification have all been aspects of modern medicine almost since its establishment, this research examines what is particular about neo-liberalism as such as it is reflected in the case of health care in Egypt. The themes often mentioned as aspects of neo-liberalism, namely commodification, marginalization and objectification, studies show, have been part of modern medicine since its establishment in Egypt or at least since the early 1900s. However, what is causing the debate over neoliberal policies related to health today is different and needs further examination.

Neoliberal discourse is examined here as Dunn explains it. It refers to the normative governmentality which seeks to create through international standards and regulations, standardizations and increase transparency to monitor and control (Dunn 2005, 173-190). In other words, neo-liberalism where is examined as a new form of governance that does not, however, necessarily produce new ideals or goals. While commodification, marginalization, objectification are all aspects that have already been present within modern medicine, it is the way in which they are produced that is different here and the extent as well. This form of new governance produces different effects according to where and in which context it is applied. Consequently, these effects and the modes by which they are produced are the aspects that need further examination. This form of governance and its effects are produced in many spheres, globally and locally, and the site of Al Kasr Al Ainy, the university hospital under study, is only one of these many sites. This study only aims to contribute to the larger work on anthropologies of modernity, neo-liberalism and globalization (Inda 2005; Scott 2005; Ong 2005; Ferguson and

Gupta 2005; Olds and Thrift 2005; Ong and Collier 2005; Collier and Lakoff 2005; Strathern 2005; Dunn 2005), by examining one site as an example.

2 A brief history of modern medicine in Egypt

Many studies have focused on the development of the medical institution and profession in the context of Egypt (Chiffolleau 2005; Ali 1997; Fahmy 2002; Shukrallah). Although the development of the modern medical profession holds similar aspects everywhere, it also holds differences that vary according to geographical context and depending on social and economic developments that shape it. These social and economic developments will be briefly explained to help contextualize this research and contextualize the site under study, namely Al Kasr Al Ainy.

The establishment of modern medicine in Egypt dates back to Mohamed Ali Pasha's rule (1805-1848). Mohammed Ali's ambition was to transform Egypt into a modern nation state. As is the case with the creation of any nation state, institutions needed to be established in order to accomplish this ambition. In the case of Egypt, the first institutions were the army and the medical establishment. The goals were to Egyptianize the army, by recruiting native inhabitants, and to create a modern medical system that would serve it and provide the state with a healthy nation that can work for it (Chiffolleau 2005; Fahmy 2002; Sonbol 1991; Shukrallah). To establish this modern medical system, Mohammed Ali appointed Antoine-Barthelemy Clot, a French medical doctor who later became known as "Clot Bey," to head the first school of medicine in Abou Zabaal (Chiffolleau 2005; Sonbol 1991; Shukrallah).

Clot Bey's medical school cut itself completely off from any older forms of healing that were present back then. A book published by Cairo's faculty of medicine in 1935 explains that the healing institutions that were left over from Arab rule, called Marastan, were completely rejected by Clot Bey, who believed them to be of very low standards (Mahfouz 1935). Maristan

Schools were seen as “insufficient” to meet European standards. Instead Clot Bey proposed that a group of European-educated Egyptian students to be formed to teach at the new school of medicine or, to use Clot Bey’s words, “mission graduates will be appointed as “repeaters” and will themselves deliver the lectures in Arabic” (Mahfouz 1935, 33-34). The medical school of Abou Zaabal was ultimately transferred to Kasr El Ainy, to become the site under study in this research.

Using the French medical model for Al Kasr Al Ainy, European concepts of modernity were at the core of its education method. However, the medical school had to depend at first on existing education institutions for recruiting students, and back then these were the *Kuttabs*, or Islamic schools (Sonbol 1991). It also needed to depend on the use of traditional midwifery to gain women’s acceptance of the new medical system (Abu-Lughod 1998; Sonbol 1991). Barbers that were the primary healing providers for many of the population were also used to combat epidemics. Mahfouz explains that they were taught how to vaccinate (Mahfouz 1935). It can therefore be assumed that the already existing local traditions of education and healing have had some influence on the development of the modern medical profession in Egypt, albeit not a major one.

The introduction of profit oriented medicine, on the other hand, was established after the British takeover. Unlike Mohammed Ali’s dynasty that was concerned with building a nation state, the British were mainly concerned with the empire. They cut down spending on medical education as well as on medical care services. According to Chiffoleau, the budget set for education and health-care together did not exceed 1.15% of the country’s total budget and the money spent on public health was less than what was spent on the smallest hospital in London. Instead, the door

was opened for private clinics to operate on profit making basis (Chiffolleau 2005). The cut-down on education services, that accompanied the cut down on health services, meant that the only ones who could afford to study medicine were the Egyptian rich, which meant that gradually medicine became an elite profession. Moreover, since the door was opened for medicine to be used for profit making, the profession gradually turned into a business (Chiffolleau 2005; Shukrallah n.d.).

Shukrallah argues that even after the 1952 revolution and the establishment of a socialist oriented constitution, medicine remained a profit generating profession and a business. Although the 1962 constitution clearly stated that *"The right to health welfare is foremost among the rights of every citizen. To ensure this right, medical treatment and pharmaceuticals should not be reduced to mere commodities subject to sale and purchase, but should be guaranteed to be available free of charge to every citizen"* (The Egyptian National Charter, 1962), the new regime still had to compromise with the Egyptian medical elite who would not give up the privileges it gained from medicine as a generator of profit under British rule. Consequently, the new government reached a compromise with the class of medical professionals, and left the private for profit untouched. This was what Shukrallah called the "Big Compromise" (Shukrallah n.d.). While the new government invested in public health services it did not alter the private profit-oriented trend in medical care.

Although the public medical system was trying to compete with the private, the profit-making orientation persisted within the medical profession and ultimately infiltrated the public as well. Those who worked as civil servants considered the two compulsory years of public service to be transitory after which they would leave to open up their own private clinic. In short, the ideology

of medicine as business and of patients as clients never seized, not even under the “socialist” regime. A study titled “People and Medicine in the Middle East”, showed that when medical students were asked why they chose to become doctors, the majority gave the answer “to get rich” while only a minority said “to serve humanity” (Simon, 51). This orientation was enhanced by the *infitah* (open door policies), implemented under Sadat’s government. These policies introduced private investment hospitals and argued that such hospitals would attract patients from abroad, especially the Gulf, and promote Health Tourism (Shukrallah n.d.). Moreover, international bodies, like the IMF and the WTO were starting to enter the Egyptian economy. Egypt’s switch of allies, from the Soviet Union to the US was of course the major contributor to this transformation.

Concepts emphasizing individuality rather than social welfare started to dominate official discourses especially when it concerned health services. Ali explains that in accord with the peace treaty signed with Israel, the US allocated a bulk of funding into the health sector, about \$87 million between 1977 and 1983, and dedicated it to the Population Program. The population program was part of a wider encompassing agenda, pushed through by the US and the WB, which encouraged the State to decrease its spending on public services and promote private investments instead. The Population Program propagated the idea that if it was not for over population, Egypt would not have poverty problems and logically everyone could afford private health care. It also fell in harmony with decreased government spending since it argued that the smaller the family is the better it can manage its budget without State help (Ali 2002). In short, arguments developing after the *infitah* were shifting responsibility from the social to the individual, promoting ideas of liberalization.

Recent dominating discourses on health care in Egypt have been largely propagating the idea that the public health sector is currently facing a crisis that needs to be managed. The quality of medical care "*Gawdet Al Seha*" is a term now frequently heard in the media and propagated by government officials. Vows made by the Egyptian Ministry of Health to improve it have been at the core of the debate over health care. "*Gawdet Al Seha*" or the quality of medical care as defined by a professor in Al Kasr Al Ainy is used to mean that "Every [medical] practice has to be done right from the first time and every time" (lecture on Ethics in Al Kasr Al Ainy, 2010) To guarantee that, international standards and accreditation are proposed as the way by which such quality can be controlled. The Minister of Health declared that without following international standards, as stipulated through accreditation, there can be no guarantee that hospitals, clinics and physicians are following "Good practice". Consequently, the ministry vowed that by 2013 hospitals that lack accreditation will be shut down.

The intensification of debate about medical malpractice and accountability went hand in hand with the Ministry of Health's proposal to privatize the Health Insurance Organizations (HIOs), under which 57% of the population¹ are currently accessing free health care. It also went hand in hand with higher emphasis, from government entities as well as private institutions, on the importance of Corporate Social responsibility, NGO contributions and the role of the private sector in general. Arguing for better quality health care, the Minister of health claimed that complains of low quality are directly linked to lack of funding allocated to the public health sector and that charging a fee for health care, a minimal one for those who live under poverty

¹ <http://www.hio.gov.eg/Ar/Pages/default.aspx>

line, would enhance the quality of care all Egyptians obtain. In other words, to avoid having the public health sector deteriorate to an extent where it will not be able to meet the newly dictated health standards and ultimately shut down, the minister of health argued that it may be saved through its privatization.

These rising discourses, however, do not discuss the deteriorated condition of health care in the private sector which has been highlighted by scandals related to medical conduct as well as by the high number of government officials who travel abroad for better medical service. The most famous state official to travel for medical care was the head of state himself. Nevertheless, the discourse offered by different state agents as well as some international bodies, claims that in the future, as all institutions gain international accreditation, quality care will be guaranteed. Consequently, if international standards are actually applied, health care will improve and such standards can only be guaranteed through accreditation.

Studies conducted by anti-privatization advocates², focus on how this state discourse targets health care receivers to convince them to give up their right to health care. This research, on the other hand, aims to examine how this new discourse targets medical professionals. Al Kasr Al Ainy, where thousands of doctors are being trained, international standards of quality care are becoming part of the medical culture through new education strategies and techniques that fall under the term of "*Gawdet Al Ta'leem*" or quality of education. New courses and tests are being implemented, all emphasizing ethical medical conduct of doctors to qualify them to take part in the internationally accredited health institutions of the future. These new courses that are part of "*Gawdet Al Ta'leem*" is focused on in this study as an example of the many neo-liberal

² http://www.ahedegypt.org/pubs/Campaign/Health_Insurance_Luxor.pdf

discourses that are gradually becoming part of the medical culture in Egypt. To understand how the effects of these new discourses are translated in the medical education realm, such courses are analyzed in detail as an example of the larger discourse propagated by the state, international organizations, private institutions and media channels. The research more importantly focuses on how these discourses are reflected on interns' perceptions of their roles and future goals.

I argue that these courses are part of the current government's increasingly neo-liberal agenda that started with the *infatih*. I define neo-liberal informed by David Harvey as the political-economic influences that dictate states to defend private property rights, free markets, free trade and the privatization of public assets, and its theory propagated through civil society institutions (Harvey 2005). Through civil society the state, Harvey argues, promotes 1) market rules as the premise on which all social conduct should be built and 2) individuality over social solidarity. However, such concepts, as argued by other studies mentioned above, have been part of medical care in Egypt even before the *infatih*. *Although the extent to which market rules influenced health care was mitigated under the so called "socialist" government, it continued to shape the medical system and profession and while individuality was not premised it did still persist within the profession's culture.*

However, what needs to be examined today is neo-liberalism as Nikolas Rose defines it; Neo-liberalism as "a political rationality that seeks to govern not through command and control operations but through the calculative choice of formally free actors" (Rose 2005, 13). In other words, neo-liberal concepts mentioned by Harvey get to be individualized and defended by different "free" acting actors and not simply defended through state policies. This research

examines not only how Egyptian state agents, try to propagate a neo-liberal rationale through health education institutions but also how through the daily practice of interns a neoliberal mode of governance is developing which works to create physicians who would “freely choose” to abide by market rules guided by their individualist oriented rationality. Moreover, as Ong argues, “neo-liberalism's actual shape and significance for the forms of individual and collective life can only be understood as it enters into assemblages with other elements” (Ong 2006). In other words, the impact of neo-liberalism is different from one context to another and creates different outcomes. Consequently, this study also aims at showing how neo-liberalism is translated as it enters into contact with interns' education at Al Kasr Al Ainy.

3 Al Kasr Al Ainy: structure and hierarchy

The choice of Al Kasr Al Ainy as an area for study was based on it being the oldest medical university hospital in Egypt. Being the oldest medical university hospital it holds the heritage of modern medicine ever since its establishment in Egypt, offering rich material for research. Going through the literature available on the history of modern medicine, Al Kasr Al Ainy was the place most covered by historical research making information about its development easily accessible. However, understanding its structure and hierarchies took more time and required some investment in the field. This structure will be quickly explained here to contextualize the topic addressed in this study.

Al Kasr Al Ainy has 25 departments and 10 hospitals³. Its undergraduate program is six years after which students become doctors and then work as interns at Al Kasr Al Ainy for one year (a complete 12 months). During their internship year they are said to be finishing their *imitiaz*. During the internship year interns are assigned to a different department every three months. After the internship year, 150 interns (those with the highest accumulative scores from the six years of study) are chosen to become house officers at one of the departments of the hospital. Every department sets the number of vacancies it is offering for this particular year and the student with the highest score gets to be the first to choose the desired department and then the second follows and the third and so on until the 150th is the last to choose. Those who do not

³ <http://www.medicine.cu.edu.eg/beta/en>

get to become house officers at Al Kasr Al Ainy are assigned a *takleef* (2 years of medical work at a public clinic or hospital). The intern also chooses the desired area of the *takleef* and the choices of the interns with the highest scores get priority. Most interns choose somewhere close to where they live, which is mostly in Cairo. Consequently, clinics in and around the capital require the highest scores. Those who accept their position as house officers at Al Kasr Al Ainy, work as house officers for five years during which they also start pursuing their postgraduate studies to become specialized professors at the university. Alongside their work as House Officers at the hospital and their postgraduate studies they also work as teaching assistants and some pursue private practice. Teaching assistants become professors after finishing their postgraduate studies. Professors become head of departments according to the number of years they have worked as professors at the university. Those who worked the longest number of years as professors within a certain department are made head of their departments.

The medical staff of the hospital is constituted of physicians/professors, House officers, Interns, and Nurses. There is also a non-medical staff which constitutes of the workers and security. The physician/professor holds the highest position within the medical staff and supervises the work of the house officers and interns besides teaching the students. The house officers supervise and instruct the interns. Nurses work to assist professors, House Officers and interns in addition to the nursing services they offer patients. Nurses also arrange and supervise medical equipment and medication provided by the hospital. Workers are responsible for the general cleanness of the hospital and the transportation of medical equipment.

In short, the structure of the hospital is set according to scores and the number of years service has been provided to the hospital and not elsewhere. Professors at Al Kasr Al Ainy were

necessarily students, interns and house officers there as well. The hierarchy is also set according to the number of years spent at the hospital and the expertise of the medical professional. Nurses are out of this hierarchy and are hired as nurses from the start and remain so. However, nurses have their own hierarchical structure amongst themselves that is separate to that of doctors. Still, nurses are expected to take instructions from professors, House Officers and interns.

4 Accessing the field

Aiming at finding out the different factors that shape interns' socialization process I first tried to gain access to their practical training and observe them as well as conduct interviews with them. However, that proved difficult both ethically and practically. Ethically, IRB considerations forbid me from attending the clinical rounds I had first intended to observe and practically the rounds were time consuming and hard to access. To access rounds I needed to go through official hospital approvals or professor approvals and both proved difficult. Although I found four professors willing to have me attend their rounds, and I tried to do so for a while, I realized that they would be too time consuming for the information they generate. Few interns attended clinical rounds, attendees were mostly 4th and 5th year students, and access through professors alienated me a bit from the interns I approached. Consequently, I decided to go about the field in a completely different manner especially after realizing that previous school colleagues of mine were at the time of the research interns at Al Kasr Al Ainy.

I realized that I already knew five of the interns either from my school years or through friends. Through them, I could gain access to other interns who trained with them in the same departments. As interns are assigned a different department every three months, they are also assigned to work with a different group every time they change department. Knowing five different interns, each could acquaint me with those with him/her in the department allowing me to get a random sample of students to interview and follow for observation, who also worked in different specializations at the time of the interview. The fact that interns do not get a chance to choose the group they work with made my sample even more random because their

colleagues at the department were not necessarily their friends which meant that I gained access to interns from different social backgrounds.

Instead of focusing on clinical rounds to access observation of how the state propagates its discourse, I was informed through one of the professors that newly implemented courses on patient-doctor interactions are being taught. This piece of information was very useful because it meant that I did not only gain access to observing state required courses but also to the changes that are being implemented. However, what was missing from such lectures, as opposed to the clinical rounds, was the practical experience of interns and their interaction with other medical professionals and patients. Ultimately, I was told by the interns that I could easily attend with them their ER rounds which they believed give a better perspective on their practical training more than their work in any other department. In other departments, several interns explained, they have little to do and observation there in their opinion, would not be very useful since most of their time is spent either chatting or transporting blood bags or scans.

In short, to understand how the new state propagated discourses interact and shape interns' socialization, I focused on attending some of the courses that have been launched as part of *Gawdet Al ta'leem* (quality of education). These courses that targeted interns mainly focused on doctor-patient interaction and were provided in the format of a lecture. My method involved attending these lectures to analyze and describe some of the state discourses that are newly shaping the medical education sector today.

To understand the experiences of interns, observation and interviews were conducted with them and with others working around them at Al Kasr Al Ainy. To study the different interactions, encounters and discourses that shape medical interns, several methods were used. I first

conducted unstructured interviews with interns and professors within the hospital to get a better understanding of the hospital's structure and the different stakeholders involved as well as map out the hierarchy of the institution. I then used semi-structured interviews to interview interns on their perceptions of what it entails to be a medical doctor, what the role of the medical doctor is and what the medical code of ethics meant to them. The same method, namely semi-structured interviews, was also used with professors to assess their perceptions of the same aspects interns' were asked about. Interviews were conducted with 20 students, but not all individually, some interviews were done in a focus group format. Moreover, I complemented my interviews with daily informal meetings with interns, mainly in the hospital cafeteria or during their social outings. Only four professors were interviewed, of which one was responsible for managing the new lectures I attended. Observation and informal interviews were mainly conducted in the Emergency Room (ER). Conversation in the ER mostly focused on what interns were doing and how they followed patients' cases. In parts of the ER where the patients' inflow was low, some interns also talked about their experiences more generally. My observation mainly focused on how interns interacted with patients and how they applied what they learned. My aim of that was to compare what interns learned to their medical practice.

Finally, to link perceptions and practices to the changes in policies towards liberalization, I analyzed official documents, policies and reports including WB, USAID and government proposals related to the service sector as well as government media statements concerned with public services and health care. Interviews with state officials would have contributed to the research. However, lack of time was a barrier to finding and accessing state officials. Still, some of the stakeholders engaged with the state discourse, such as NGO members, syndicate officials and political health advocates, were interviewed. The interviews were also semi-structured to

allow interviewees to discuss topics that were not necessarily planned as part of the discussion. These interviews mainly dealt with the debate surrounding policy changes, where they fit in that debate, what it means to be a medical doctor, what the role of a medical doctor is and the code of ethics medicine should have.

Overall, accessing the field was difficult at first but became very easy after I got accustomed to the place and to the interns' daily lives. I was treated by those who did not know me in the field as an intern and was referred to as 'Doctor' several times by hospital security, making my access easier wherever I went. My first day in the field I was stopped by hospital security and was not allowed in certain departments. However, hanging out with interns long enough I started knowing my way around and looked confident enough as I was walking through the hospital to avoid being stopped by security. I did refuse, however, to wear a white coat, as recommended by interns, because I had an ethical issue with lying about my identity. Even though I did not correct security when they referred to me as 'doctor', I did correct patients when they did.

5 Creating the imaginary: Changes in the medical education sector and its implication on Al Kasr Al Ainy

In a university hospital such as Al Kasr Al Ainy, “*Gawdet Al Taleem*” or quality of education is the term under which medical reforms take place. Since it is a medical education institution, “*Gawdet Al Seha*” (quality of health) can be improved by improving “*Gawdet Al taleem*”. Consequently, reforms take the shape of courses, lectures and additional tests. The first professor I was introduced to in Al Kasr Al Ainy explained that many new courses are now being introduced to improve the quality of education and she proposed that I attend these courses. These courses, she explained, are implemented to guarantee that the university stays accredited. The Supreme Council of Universities set a National Accreditation Program which dictates the criteria upon which universities can be qualified for accreditation. A National Committee was formed, by the ministerial decree no. (714) set in 18/5/2006, to head the Quality Assurance and Accreditation Project. This committee was made up of several university professors selected from the different faculties of state universities, in addition to a member of the American Ford Foundation and a professor from the American University in Cairo (AUC)⁴.

The new courses being introduced all deal with physician-patient interaction. They examine ethics, communication, legal status of interactions as well as other practical skills, such as basic surgical skills that interns are expected to acquire as they enter into their first encounters with patients. Those lectures reflected what the official state discourse wants interns to learn about how to interact with patients and what "good quality medical practice" is, in accordance to the

⁴ <http://www.qaap.net/board.htm>

Ministry of Health and the Quality Assurance and Accreditation Project. In this chapter I will mainly focus on the lecture on ethics since it examined more general concepts of “good medical care” while the other lectures focused on specific and more detailed aspects of them. The analysis applied to this lecture in specific can be applied to some of the other lectures I attended on patient-doctor interaction and communication but it would be redundant to go through each lecture, therefore I chose to focus only on one.

In short, the lecture explained several concepts that doctors were required to follow in order to conduct ethical medical practice. The terms included Beneficence, Non-maleficence, Justice, Autonomy, Respect, Truthfulness and Honesty, Privacy and Confidentiality. According to the lecture, medical professionals need to understand these concepts and adopt them as they interact with patients, for their practice to be considered fully ethical and for them to provide good quality medical service. This chapter will analyze the concepts as explained in the lecture and how they relate to interns’ daily interactions with patients within Al Kasr Al Ainy. Observation conducted in the Emergency Room of the university hospital in addition to interviews conducted with interns will be the reference upon which the theoretical concepts explained in the lecture are compared. The aim of this analysis will be first, to gain understanding of the new discourse on medical ethics and good quality medical practice, propagated by the new accreditation courses. The second will be to understand how far this new discourse relates to medical practice at the university hospital by comparing the theoretical concepts of ethics to the daily practice of interns at Al Kasr Al Ainy.

The lecture on ethics was provided by a medical professor who is also a General Practitioner in practice. The lecture was attended by approximately 20 interns and took place in a lecture hall in

the format of a power point presentation. The lecturer was a woman in her forties wearing a colorful head scarf who presented it in a lively manner, trying to engage all the students by continuously posing questions. The lecturer defined the ethical concepts as follows. Beneficence: doctors should be working primarily for the patient's well being and not for the money or for the hospital. Non-maleficence: if the doctor cannot help the patient s/he should not harm him/her. Justice: doctors should provide all patients with equal time and treatment. Autonomy: the patient should be given the right to choose the doctor and the treatment and the doctor can refuse to treat the patient under certain circumstances including for example the patient's non-compliance. Truthfulness and honesty was not fully explained by the lecturer but seemed to imply that the patient needs to be fully informed about his/her health status and should be aware of the options of treatment. Finally, privacy and confidentiality of the patient was explained as the patient's right to be inspected alone with the physician and only one other medical professional for the doctor's legal safety. All information related to the patient should not be shared with any other person without the patient's permission except to those who are susceptible of being infected, for their own protection. Explaining the concepts more thoroughly, the lecturer seemed to overall stress the importance of the doctor's individual responsibility in applying such concepts. In other words, ethical concepts were not approached in a social or economic manner but only in terms of individual relations and physician "choices". To explain, I will go through each concept, as the lecturer explained it, in details.

When explaining justice as the patient's right to equal time and treatment the lecturer said *"They all paid the same... they should get the same treatment."* The lecturer here first measures the right to health with what the patient pays. Justice in this context is then measured only on the basis that payment has already been assumed, not considering health as a right per-se

without necessarily depending on the financial status of the patient. Such an assumption also meant that the lecturer primarily thinks in terms of private practice, where patients need to pay for examination. In other words, Justice as explained by the professor here does not take into consideration material barriers to access of health and is only applied to those who can already afford access. Later, she added that even in public hospitals where health care is free of charge patients should be given equal treatment and goes on to add

Even in Al Kasr Al Ainy, you should treat patients well...you should not think because they are treated for free that they should not be given enough time or good treatment.

Equal treatment in this instance ignores the structural constraints of the university hospital namely under-funding and over-crowdedness, opting instead to limit justice and equal treatment to student's choice to give patients equal time and treatment. In contrast, the most common complaints expressed by interns working at the hospital were the lack of resources and the high ratio of patients in comparison to the availability of doctors. While many explained that they were trying their best to provide patients with time and treatment, they complained that they were met with barriers that were simply beyond their control. Although the course curriculum maybe blind to such circumstances the lecturing professor herself was not. In an attempt to address the constraints interns face and that may conflict with the message about ethics being taught, she explained "you should not scream at patients or hit them...I know that you are tired and over-worked but still". Such an addition assumes that such practices are common and in fact she adds that they are by explaining that such practices are often observed. In an attempt to match the discourse with the existing structural barriers, the professor redefines Justice to simply mean patient's right to dignity and respect and leaves out all the structural causes that inhibit a Just treatment of patients to be practiced. It is easier to simply focus on a dignified and

respectful treatment rather than talking about lack of medication, medical equipment, beds or even time that may forbid the doctor to practice an adequate treatment.

Instead of talking about the circumstances that create the overload or the stressful atmosphere, the professor puts the responsibility on the student's individual tolerance and patience. By doing so, she shifts attention from the structural causes of unethical treatment and puts responsibility solely on the individual doctor by claiming that with some individual determination ethical conduct can be provided. While both, the professor as well as the students, are aware that structural forces are the main barrier to a just medical conduct, the course curriculum pushes them to only consider individual behavior. Since the course creates no space for discussing structural and material aspects of health care, individual actions and “choices” are discussed as the primary source of ethical medical conduct.

In short, the Quality Assurance and Accreditation Project demands that such courses are implemented regardless of the context in which it applies. The professor, on the other hand, takes the responsibility of teaching the course without getting much of a say to what the content of the course should tackle. Although she is responsible for structuring the course, she is not fully free to choose its content since she has to abide by certain standards enforced by the QAAP in addition to some of the international standards of accreditation as well. The professor who supervises these courses informed me that in addition to them being applicable to national accreditation standards they are also applicable to international ones. She also added that the national ones often follow the international standards to guarantee that Egyptian universities are accredited internationally. If, on the other hand, such ethical standards are not applied in the

context of Al Kasr Al Ainy, national accreditation may not be guaranteed. Hence, such standards are taught whether they are actually feasible at Al Kasr Al Ainy or not.

Consequently, since the course curriculum does not focus on social-economic differences within society, the professor ignores in her lecture that Al Kasr Al Ainy is underfunded in comparison to other hospitals and focuses instead on equal treatment and time for all patients within the same hospital (i.e. not favoring one Kasr Al Ainy patient over another) rather than equal treatment across different hospitals. In the course's discourse, justice or equality in time and treatment given to the patient gets to be defined not as applied to the society as a whole, but only within one hospital, accepting the stratification that is present within society. In other words, the discourse accepts that there can be one equipped hospital and another under-equipped one or an over-loaded hospital and one where more doctors are available to cater for patients' demands.

The professor explicitly says *“Do not treat one [patient] better than the other because you know him or because he is someone’s relative”* Discrimination is therefore personalized. Rather than approaching structural challenges to justice, the concept of Justice is limited to personal discrimination that the individual physician may choose or avoid. Recognizing such social and economic barriers and neutralizing them, means that they are also normalized and accepted. For example when the professor recognizes that interns at the hospital are facing an overload of work and that they are always working under stress, she accepts that such a state of work is “normal” and in spite of it just treatment should be offered. On the other hand, she is pushed to ignore the lack of equipment, which unlike stress from over-work cannot be mitigated by increased intern endurance, and by doing so neutralizes such a structural barrier. Since a Just treatment only means, according to the course’s definition, equal time and treatment provided

by physicians, lack of equipment within Al Kasr Al Ainy falls out of the definition completely and is thus neutralized. The professor, whether intentionally or not, works on neutralizing such structures because accreditation standards obliges that such ethics are taught regardless of the context where it applies.

When the lecturer moved to explaining beneficence, I was surprised to know that it meant that doctors' goal should be to serve patients and not to gain riches or serve the hospital. My surprise was based on the assumption that it was obvious how much the health care system was based on material gain rather than patient's welfare, and that the conflict of interest that arises between the doctor and the patient is crystal clear. However, such a view of the system was not officially articulated in this course curriculum. Although many comments were made from the professor as well as the students that financial gain is what the doctor deserves from hard work with patients, the conflict was never articulated. For example as soon as the professor asked what the students thought the rights of doctors were, the first word screamed from the lecture hall was "Money". This was not surprising because like any profession, under the capitalist system, money is usually the reward.

In the context of health care the source of money is either provided by patients who pay for doctors or is provided by the state, as in the cases of public health care. Therefore, to assume that ethical doctors will not be working for money but expecting money as a reward can be contradictory unless the same amount of sufficient money is provided regardless of how well the patient is treated. In the latter (public health care), salaries at Al Kasr Al Ainy, according to all interviews are not sufficient to sustain an individual, let alone a family. The question then becomes: how do physicians, interns or house-officers make money to sustain themselves or

their families? The ethical condition put forward to the medical students does not take into consideration the wider socio-economic context in which he/she works. As one intern argued

"I don't understand why the law does not allow doctors to have their own private business on the side...it is better [if doctors have their own business] because if I have my own business through which I can sustain myself, I can then practice medicine only with the purpose of healing people rather than for money"

Here the student is applying the concept of beneficence in his own socio-economic context but is again confronted with another ethical dilemma namely that doctors should not have a business that may create a conflict of interest. The student, however, believes that the conflict of interest lies instead in the fact that his earnings are dependent on his profession which ultimately means the patient's health. He does not consider that a private business can cause a conflict with a patient's health in terms of time and energy distribution. It is also important to note that the law that conditions doctors not to have their private business is not part of the new ethics courses but has been present from before. The older set state laws tackling medical ethics were more concerned with issues of conflicts of interests, which are not considered in these new lectures. However, such laws were not necessarily applied in practice. As many studies show, the profit making orientation persisted within medical care even under the socialist oriented government. Although, it is also important to note that state policies regarding health have also been witnessing a shift, from policies oriented towards a more social approach to health to one that is more market and individual oriented (Ali 1997; Shukrallah; Chiffolleau 2005). The difference between old concepts on health to new ones will be compared in the next chapter.

Back to the courses, Rodwin identifies two main types of conflict of interest that arise in the medical sector but that have not been mentioned in the lecture:

1. Conflict between a physician's personal interests (often financial) and the interests of the patient and
2. Conflicts that divide a physician's loyalty between two or more patients or between a patient and a third party (Rodwin 1993, 9).

The first type of conflict usually arises in a private practice setting where the need for more money may cause physicians to raise their fees, see more patients or offer more services to existing patients even when unnecessary. The second one is the more complex and often indirect conflict. In this case the doctor's need or desire for money will either cause him/her to seek money elsewhere or acquire money from a third party. In the case where doctors obtain their money elsewhere, either through a private clinic or a private business, there is a big chance that the time and effort given to patients that acquire a free service will be ultimately compromised. In cases where a third party pays for the service, as with health insurance companies, the possibility that the physician's loyalty would go to the money provider rather than the patient becomes high.

Asking doctors to work for the patient not the money in the context of Al Kasr Al Ainy either does not consider that money is a necessity and a desire in the present system, assumes that it is provided by something other than the hospital or that the money provided by the university hospital is sufficient for doctors not to need to work elsewhere. However, since such ethics supposedly also apply to the private sector, none of these three assumptions are implied. What is actually implied by beneficence is that if the doctor intends to work for the patient rather than the money, despite his/her own material needs and temptations, s/he can. The concept as defined, simply does not take into consideration the conflict of interest at all.

The way the concepts of Justice and Benefices are defined put the responsibility solely on the intern/physician, disregarding whether they are compatible with the social and economic structures. However, the examples given by the lecturer to support the concepts imply that only with some effort and "good will" they can be applied and are feasible. Just as Waitzkin argues that the neutralization of social and economic causes of illness becomes an essential part of medical practice (Waitzkin 1989), I argue that the neutralization of the social and economic causes of unethical medical conduct is being integrated in medical education. To rephrase, just as medical doctors naturalize and/or neutralize the social and economic factors that lead to illness by focusing purely on the biological aspects of health, the new courses tackling ethics naturalize and/or neutralize the social and economic factors that lead to unethical medical conduct by focusing on individual choice and practice. In short, the courses not only fail to tackle the barriers facing physicians as they try to practice ethical medical behavior with patients but also they indirectly also neutralize and normalize such barriers, making them acceptable.

The same mechanisms of neutralization can be observed as the lecturer delves into the concept of privacy. While the professor explains that patients have the right to be examined privately, she disregards the overload public hospitals face. In Al Kasr Al Ainy, where rooms are simply not enough to sustain all patients admitted to the hospital, the right to privacy is hardly feasible. Still the individual doctor is required to provide it, under the new ethical codes of conduct which follow national and international standards of health care. While the concept of non-maleficence, on the other hand, was quickly mentioned without much elaboration, I would like to give it some focus here. According to the doctor non-maleficence means that if the physician cannot help the patient, s/he must not harm him/her. Although this seems unproblematic, from observation at Al Kasr Al Ainy, this is rather problematic. As my observation in the Emergency

Room (ER) demonstrates and according to interviews with interns, experimentation at times prevails in how interns treat their patients.

Since the number of house officers and professors available in the hospital are low, interns sometimes need to take up responsibilities for which they lack the skills. Even the expertise of house officers is not always sufficient, and the quality of the supervision they can offer interns is not always adequate. As I observed in the ER and according to interns working there, there is usually one or two house officers present alongside several interns. The role of the ER is to stabilize the health of the patient admitted and make all necessary tests and examinations until a specialized physician is available. Especially during night shifts, hardly any specialized physicians/professors are present and patients are kept in the ER for long hours until the next day when treatment can be made available. For those patients who need minor surgeries or stitches, house residents and interns take on such a responsibility. Sometimes, if not most of the time, it is the intern's first time to practically practice such an operation and is only guided by his/her theoretical learning acquired over the past six years.

The most commonly told stories by interns relate to how they stitched their first patients. It seems like it is the most commonly practiced operation for interns as they are assigned to the ER. Internship at Al Kasr Al Ainy lasts for 12 months in total. Each three month the intern is assigned to one of the hospital's units of which the ER is one. The ER according to all students is where they are exposed the most and where they interact most with patients. All interns interviewed, with no exception, complained that they were experimenting on patients (*"konna bengarrab feehom"*). They all found that problematic and said that it was one of the worst things about the hospital. One intern complained

My first three months as an intern I was assigned to the ER...you can imagine the shock...it was the first thing I had to do. The house officer that supervised me was not much more experienced than us [interns]. It was her first three months as a house officer and before she was an intern like us. I felt what we were doing was "haram" (religiously wrong or forbidden) so I went to the head of the department and I told him that I do not think we are experienced enough nor is the house officer and so the university should offer practical training sessions before we are admitted to the ER. He replied saying that even if the university offered such courses, students would not care to attend. How does he know that? Why should he assume that? Someone like me would want to attend for example and why does he assume that without even trying?

From such stories one can deduce that harm may actually be inflicted on patients by interns at Al Kasr Al Ainy, whether such harm is intentional or not. Interns are put in a situation where they can either leave the patient completely untreated or try and stabilize their status, successfully or not. In doing so, some interns are aware that in some situations they may actually be inflicting harm due to their inexperience, this was expressed several times during interviews. On the other hand, the reply given by the head of department, which implies that he assumed that such a situation may not be enhanced even if courses are provided, shows even more the extent to which the structural barriers to ethical medical conduct are constantly re-normalized through different persons, courses...etc, within the medical institution under study. While the student is still at shock having not yet normalized such mal-practices, the head of department has already normalized them and is re-normalizing it through not accepting to offer the departmental help demanded by the intern.

Back to the lecture on ethics, it seems that the world in which the ethics learned supposedly should apply is almost imaginary. While the professor tries at times to fit it into the context of Al Kasr Al Ainy by molding the definitions accordingly, some are simply inapplicable. If a comparison is made between what Waitzkin argues happens in the American medical system and what is observed in the context of Al Kasr Al Ainy, we see that socio-economic structures are ignored in

both. However, in this context not only are certain social and economic aspects ignored but some, I argue, are imagined. The lecture assumes that a certain social setting and particular economic materials are provided while they are not. In short, the ethics taught seem to be talking about a completely different hospital where space for privacy is available, a sufficient number of doctors are present for patients to be given time and treatment, enough experience and practice is guaranteed to avoid the harm of patients...etc. Consequently, even the lecturer who is assigned to give the courses is not always able to defend the applicability of its contents.

Expecting to apply such ethics without consideration to the local context creates an imaginary world where no structural or material constraints to individual ethics exist. A parallel can be made between such "international standards" of ethics and the Egyptian TV series '*Lahazat Harega*' (critical moments), where an imagined hospital with no particularly articulated place or time can be visualized. With the purpose of producing a low cost TV show that can be aired internationally, an American produced Egyptian version of ER (American TV series) is acted by Arab actors, dubbed in several languages and aired in several countries from Africa to Asia. To fit into all contexts where it is being aired, the soap opera takes place in a no-where land. Although the country can be anywhere or most likely no-where, the hospital created can adopt the above ethical concepts applied because the imagined social and economic structures are designed to fit the above mentioned ethics and not the other way round.

Unlike Al Kasr Al Ainy, the reality of many of the Egyptians, the hospital from '*Lahazat Harega*' is the imagined one approached in the course curriculum. The no-where hospital is completely well equipped, material deficiencies do not ever seem to be a barrier to good care. It is also

extremely clean, tidy and seems very hygienic. The doctors all seem to be well off financially and are all wearing modern and fashionable clothing when they are not in their scrubs. The scrubs and white coats worn by the physicians are perfectly neat and clean. When patients are hurried in during emergencies, beds, equipment and medication are always available and never in shortage. Bureaucratic paper work is hardly an issue upon admission except in cases of non-emergency where the show may have a patient filling out a form. The supposedly poor, or working class patients, are also very modernly dressed and seem to be better off than many of the middle or at least lower middle class observed in Cairo today.

Social dramas discussed in the show mostly roam around individual problems related to family and love. Social issues and traditions, for example the question of a woman's virginity, may also occasionally be addressed. There is never a discussion over a patient not affording an operation. The ideal privatized world propagated so often by the Ministry of Health (discussed more thoroughly in chapter 10) when presenting alternatives put forward by the new health reforms seem to already exist and be well functioning in this show. For example, problems of private health insurance can be referred to when physicians are met with a conflict of interest situation, but of course "the ethical individual physician" always prioritizes the well-being of the patient. The role of the individual physician is central in the drama of the show, and the differences between an ethical medical professional or a "good" one and a non-ethical or "bad" one is central to the events of the plot. In other words, the show creates the idealized world imagined to come into effect after the adoption of the international medical standards. The show creates the imagined, makes it desired, and highlights the role of the individual, exactly as the ethics course does. The different discourses on reforming the health care and medical education systems are basically visualized in '*Lahazat Harega*'.

In short, whether through courses or through TV soaps, an imaginary is being created and not necessarily in coordination. The discourse on ethics is only one example of how discourses surrounding health are shifting the attention from the structural problems to the individual, his/her commitment, will and moral conduct. Not only are these discourses ignoring the structural barriers that face medical doctors if they are to apply ethical medical conduct, but they also speak of an ideal imaginary setting. As the state gradually shifts the responsibility of health care to the market and can no longer guarantee the necessities that guarantee that the above stated ethical concepts are provided, it applies regulations that highlight individual responsibility instead. As the state gradually shifts the responsibility of health care to the market, it applies regulations, such as the above ethical regulations, that highlight individual responsibility rather than state responsibility. However, the government is not the only agent in creating these discourses but a lot of other agents, sometimes connected and sometimes not, also contribute in this creation. Although the soap opera mentioned is not related to a government plan, it operates to produce the same imaginary which a state institution such as the Supreme Council of Universities does. On the other hand, the QAAP which set the standards for universities cooperate with international bodies such the American Ford Foundation and follow international standards producing the imaginary it has through the courses described above.

What the analysis of these courses highlight is that the discourse that applies international standards to medical conduct without regard to local context, also necessarily creates an international model for the hospital where such standards can apply. Dunn uses the term normative governmentality to refer to neo-liberal modes of governmentality which she argues claim “to be applicable across geographies with diverse histories and institutions”(Dunn 2005,

175). In other words, Dunn argues that Western standards are offered as universally applicable and asks why such standards that developed in a specific set of circumstances are universalized. She adds that “the rise of new ideas and the ways particular depictions of the world are stabilized as “facts” through scientific practice is a social problem” (Dunn 2005, 180). What is most important in Dunn’s argument is that it explains that applying international standards that propagate an imaginary setting that is analogous to “Western” settings has a functional purpose. Although the official course discourse claims that the purpose of international standards is to provide quality health care, it actually works to exclude groups who do not fit into the newly standardized modes of health care being created, in this context they are the poor.

Just like in *‘Lahazat Hareha’*, the imagined is usually private, not public as Al Kasr Al Ainy. Although it is private, the poor have access because they are simply not as poor as those in Al Kasr Al Ainy, and can all afford highest quality health care. Consequently, the “real” poor observed daily at Al Kasr Al Ainy are pushed out and completely marginalized in this discourse. Not only are the poor ignored but also human interests and needs that may compromise for-profit health care. There is thus an obvious gap between the discourse on ethics being taught in lectures and the daily practice of interns who learn them. Consequently, an imaginary setting is created and as I will explain later also visualized in state proposals for future structural adjustments (Chapter 10).

6 The “old” vs. “new” state rationales and the normalization of “bad quality medical practice”

To understand the change taking place, the older state discourses need to be examined. However, the division between “old” and “new” here may not be very accurate since both discourses, although at times contradictory, still exist parallel to one another and sometimes even embody similar rationales. Here I will use “new” to refer to the neo-liberal discourse which Ong describes as a form of “governmentality that relies on market knowledge and calculations for a politics of subjection and subject making” (Ong 2006). Neo-liberalism will be studied, as Ong also suggests, “not as a “culture” or a “structure” but as mobile calculative techniques of governing that can be de-contextualized from their original sources and re-contextualized in constellations of mutually constitutive and contingent relationships” (Ong 2006, 3).

I will use “old” to refer to the discourse that was prevalent before the switch of allies from the Soviet Union to the US and that emphasized the role of the welfare system and state led services. As Ong argues, neo-liberalism as exception and exceptions to neo-liberalism depends on how the “normative order” is constituted. In other words, neo-liberalism as exception can be applied in areas, such as Egypt, where neo-liberalism is not the general characteristic of technologies of governing, as in most post-colonial, authoritarian or post-socialist countries (Ong, p.3). Egypt can be studied as a post-colonial, authoritarian as well as a post-socialist setting where neo-liberalism as a form of governmentality is also applied alongside other technologies of governance and takes a different form as when applied in a liberal democratic setting.

To explain the two state rationales, the “old” and the “new”, I will focus on the lecture on 'law and ethics' attended at Al Kasr Al Ainy. The importance of this lecture is that while shifts may be occurring in state discourses and policies, the legal framework has not necessarily changed. Therefore, comparing existing laws, of which some were set as part of the old regime, with daily medical practice and state policies in the health sector today will reveal how “old” and “new” rationales are being merged to produce the change that is currently taking place in practice. The lecture on law and ethics included an overview of the laws relating to medical ethics and doctor-patient encounters and a comparison between these laws and the realities of daily medical practice as they are experienced today by health professionals in Al Kasr Al Ainy. The course is also set as part of the national accreditation requirements, and its structure created by the professor giving the lecture. Again, the lecturer was responsible for structuring the course but she was not responsible for choosing its content. She was asked to create a course that simply states all existing laws that regulate doctor-patient interaction. Although the course did not include the comparison between the laws and the practice, the lecturer engaged in such comparisons and discussed the existing gaps. Using the lecturer's comparison between laws and practice, this chapter will discuss the contradictions and similarities between “old” and “new” state discourses, as translated into laws and practices, and how this is reflected on interns' learning today.

As the state is gradually withdrawing from its responsibilities of providing health services, by shrinking its funding, discourses to legitimize and support that are being produced. These discourses do not only produce different arguments to why the state can no longer take up such responsibilities, but also delineates the alternative providers and responsible agents. Ali argues that as the state withdraws from providing health services, new rising discourses try to put

responsibility onto the individual in an attempt to create 'new subjects' that are individually oriented and that depend less on the state for their rights(Ali 1997). However, some laws, left over from the “old” discourses are still not market oriented and therefore tend to discourage individuality and emphasize the role of social solidarity and responsibility. Already existing laws create other discourses, also propagated by state agents, which may seem contradictory with the newly rising discourses.

It is, however, important to note that as this course is part of the changes taking place within Al Kasr Al Ainy, the course focuses on laws related to individual physician behavior and ignores health related constitutional rights. However, despite that, laws emphasizing social solidarity and discouraging individual market oriented behavior could not be ignored. While the constitutional right for all to receive equal treatment and health care was not mentioned, some laws regulating physician behavior that held non-individualistic values were. Mainly two laws mentioned seemed to contradict individual market values and hence presented a conflict with the “new” discourses. The first law stated that physicians were not allowed to charge other physicians or their families for diagnosis or treatment but only for used equipment. The second law stated that physicians were not allowed to advertise in media channels about their own private practice more than three times during the whole lifetime of their clinic, hospital or lab.

The professor explained that such laws are simply ignored. The most obvious proof that physicians charge other physicians for services, despite of the law, is the health insurance provided by the medical syndicate. The fact that doctors need to pay a monthly fee to the syndicate to be provided with health insurance shows that they do not receive services for free from their colleagues as the law prescribes. As the professor explained the law, she was often

cynical in her explanation implying that everyone knew, including the interns at the lecture, that such laws do not apply. When the professor was explaining that doctors are not allowed to advertise their private practice except for a limited number of times, she added “we see more physicians in newspapers and televisions than we see movie stars”. The professor’s cynicism implied that although such laws should be applied, everyone knows that the current market system prevails and advertising, whether ethical or not, has become an integral component of medical services. Although the professor was expressing regret that such a law no longer applies, emphasizing the inapplicability of such laws that are market critical can produce a lack faith in the laws rather than a critique of the market, again serving the rising neo-liberal discourse which often questions the inapplicability of the “idealist” welfare and socialist system.

What also needs to be given attention is that despite that the law regulating advertising is part of the “old” rationale, which recognized the conflict of interest ignored by the ‘new’ rationale it still depended on individual physicians to mitigate the power of the market, again disregarding structural forces that work against that. In other words, such a law does not recognize that the market of health care depends on advertising and only seeks to mitigate individual behavior, a rationale very similar to the “new” one which emphasizes the role of the individual in providing ethical care. As discussed above, although the socialist regime came to challenge the British provided health care system that was primarily market led, it did not actually challenge it but created for it a public profit-free competitor. Consequently, it created laws that would only mitigate the profit led health system left over from British rule since it was unable to completely abolish it. This ultimately created two rationales within the same system and as studies show (Chiffolleau 2005; Shukrallah), the profit led rationale within medicine seeped into the public

sector becoming the dominant one. Ultimately, as shown by this lecture, laws that were set to mitigate the profit led rationale were no longer enforced.

These two laws show that individual competition and market values maybe fought by some laws but such laws are simply not enforced by state institutions. On the contrary, such laws are not even known to most physicians or patients and no consequences seem to follow for those who do not abide to them. On the other hand, private health services and investments are continuously encouraged producing a medical service that is extremely market oriented, as the lecturer implied when comparing the medical industry to that of movie stars.

Apart from these two laws mentioned above, all the other laws explained in the lecture regulated the individual behaviors of doctors to minimize abuse and exploitation of patients. For example, a law regulating organ donation permits such transaction only between Egyptians, to avoid first world/third world exploitation and limited it within families to avoid class exploitation. Recognizing economic underpinnings, the laws aim to regulate the ethical conduct of individual doctors through punishment rather than challenge underlying structures. Another law forbids doctors to take commissions from pharmaceutical companies. However, it is commonly known at Al Kasr Al Ainy that interns working for pharmaceutical companies market the products to professors within the hospital in return for commissions. In short, the laws, just like the ethical regulations explained in the other lecture on ethics, do not challenge the socio-economic structural barriers to ethical medical conduct but simply emphasize the role of the individual to abide to it. The only laws that actually encourage social solidarity and challenge the market are

unknown to interns and doctors because they are rarely enforced by official state institutions and in essence they hold a similar rationale to that of the 'new' discourses.

Coupled with lack of law enforcement, since the 1990s, discourses propagating market oriented services have played a prominent role supporting the shifts in state practices and policies regarding health and medicine. Therefore, when the defunct laws emphasizing social solidarity are invoked they are treated by interns and by the professor as laughing stock. The only reactions heard within this lecture were that of cynicism and disbelief that such laws existed. In short, laws do not necessarily need to change for the 'new' rationale to prevail. Acceptance of the market rationale has been made dominant for a while, through the different civil society channels, of which Al Kasr Al Ainy is now becoming one. In short, the neo-liberal discourse is normalized through civil society channels before it is even legalized or coerced through policies and laws.

As interns are socialized into becoming medical professionals they learn to accept the "new" rationale which emphasizes individual responsibility and discards state responsibility that is cumulatively diminishing. They also learn to abandon social solidarity values as the norm and depend on their individual capacities and choices instead. Contradictions in the prevailing legal codes, only normalizes for interns that laws do not necessarily apply, contributing to their loss of faith in the state institution. However, the rising "new" discourses, namely neo-liberal discourses, are to an extent adopted through a new mode of governing which creates individuals that govern their own selves into abiding by market rules and abandoning the "old" discourses of social oriented medical conduct. What interns learn through their daily practice at the university hospital is to individually "choose" what and how to practice medicine and expand their capital

of skills and capacities to survive in the medical market field. Official state laws, on the other hand, are not indicators to how physicians should act.

The professor that introduced me to the courses on ethics asked me to write her a short assessment of them. To do so and for the purpose of my research I interviewed interns about what they thought of the lectures. I asked them whether they thought such courses were useful and whether they guided them during their internship year. Answers varied as to how far such courses were used in their daily practice at the hospital. However, the common remark made by all those interviewed was that they believed the courses were more for "show" than they were actually for "use". In other words, all students perceived such courses, just as they viewed the laws, to be a facade. They explained that neither the timing of the courses nor the way they were taught made them believe that they were actually implemented to better the quality of their practice during their internship year. One intern explained:

Some of us took the courses at the end of the intern year. For example, the course on basic surgical skills would have been useful before we actually had to start trying out on patients. We were admitted to the ER and practiced on the patients then we were given the training. Same for the course on ethics and communication...also the way they were taught...it would have been more useful if they had taught it in a manner of a workshop where we would act out scenarios as if we were actually dealing with a patient and dealing with a certain case...the way these lectures were taught...I was not even listening...I slept during some of them.

Interns' perception of the courses is important because it does not only reflect the quality of the courses but also their views of the university institution as a whole. There is a general tendency for interns not to have any faith in the management or the system of the university. According to the interns, the system and management of the university in general cares more about the image of quality control rather than actually implementing measures to provide it. The courses had very little influence, if any at all, on interns' practices. Interns' practices were more

influenced with structural and material forces that the courses tried so often to marginalize. Although such structural and material forces, so ignored by the courses, were acknowledged by interns they were still to a large extent naturalized throughout their learning process, although with a lot of resistances and negotiations.

As this research will show, interns learn to naturalize socio-economic structures that shape their practice while they continue to negotiate with some of its aspects. However, they do not marginalize it to produce the outcomes the courses wishes them to, but other outcomes that are shaped by their surrounding socio-economic structures. Although interns do not necessarily criticize the course for its lack of social and economic considerations, since they have also learned to naturalize them, they do show through the way they talk about their practices that such ethics are not applicable. In short, the courses did not have a big role to play in interns' socialization but the naturalization and marginalization of socio-economic structures that the courses wished to produce have already been part of the interns' learning process from earlier on. As will be shown, structural problems are often tackled as individual problems. For example, lack of hospital material is often blamed on individual corrupt state agents and not on cut backs on funding. Hence, when interns are interviewed about the content of the course, the content's lack-of-consideration to structural influences that shape their experiences was not mentioned. What they did mention, however, was that these courses were only a "show" to claim that quality control is being implemented, emphasizing what they already believe, namely that state institutions are nonfunctional and corrupt.

The courses, according to the interns, were not the only "show" that quality control was being implemented but older "shows" already in daily practice. When I first started spending time with

interns, the first thing I was told by almost every single one of them was "The signature is the most important task for interns". Interns who have a day shift need to come in at 8:00 a.m. However, they usually arrive around 8:30-9:00. They are expected to sign between 8:0 and 9:0 a.m. and then start their shift which ends at 3:00 p.m. The mid-day shift starts at 3:00 p.m. and interns doing this shift need to sign in between 2:30 and 3:00 p.m. The night shift starts at 10:00 p.m. and interns are expected to sign between 10:00 and 10:30 p.m. Since there are a lot of interns assigned to every single shift, they divide the days so that some of them stay while others leave. An intern who stays would say that s/he is "On" today and an intern who leaves is "Off" today. Those interns who are "On" for the day sign and start the shift, while those who are "Off" also sign but then go home and come back later to sign in again or hang out near the cafeteria until it is time to sign again at the end of the shift. Therefore, the signature does not actually indicate whether the intern is working or not. The signature is only there so that it is registered in the hospital's system that interns are working and getting their practical training.

Interns perceive the courses in a similar fashion to the signature. They believe that the courses are being implemented so that it is recorded in the system that they are receiving quality control trainings and not for the purpose of actually providing quality control. Without discussing much the content of the courses, the interns tended to focus more on how they have been applied. They explained that it does not make sense to get a lot of theory without practicing how to apply it in a real situation. Therefore, some expressed their dislike of having them set in a lecture format rather than a workshop. Others also complained that although they will be done with their internship year soon, they have not yet taken these courses and explained that they might have come in handy had they taken them before actually starting their practical year.

While explaining their role during the shifts, interns often explained what they contribute as insignificant and even harmful. Interns that are not assigned to the ER are assigned to one of the specialized departments (e.g. Gynecology, General Practice, etc.). During their shifts in the specialized departments, most interns explained their role as insignificant and their feeling of worth as non-existent. Their tasks are limited to getting the blood bags from the blood bank and transporting the x-rays and test results to the house officers. Most interns perceived such tasks as befitting their position as physicians. After years of studying to become doctors, some explained, they are disappointed to be assigned tasks that any worker can handle. One intern explained:

"They sometimes tell us that they cannot trust anyone but a doctor to get the blood bags...that these bags need a certain way of handling and that they are so expensive that no ordinary worker can be trusted to transport them. We know this is not true, they just do not want to hire more workers and that is why they assign interns to do such tasks. They know we are sitting and doing nothing and most house officers are too busy to pay attention to us and give us proper training so they just use our free time to get such tasks done."

According to this intern, who seems to be expressing a commonly held belief since all those present seemed to agree with her statement and many repeated it in other interviews, the university does not want to allocate funding for more workers so the interns fill the gap. While they need to be getting their practical training, the low number of house officers in comparison to the inflow of patients leaves interns with no sufficient training. Consequently, they have a "surplus" of time they have to use since they have to be physically present between one signature and the other. Interns, therefore, either spend their time hanging out near the cafeteria, where most of my interviews were also conducted, or take care of the tasks that the lack of workers leaves undone. Interns realize that the university is not working for their development, but rather that they are being used for the hospital to continue functioning in an

under-funded state. However, some do argue that interns who want to get proper training can actually receive it if they put more effort in helping out house officers. An intern who I randomly met in the ER explained:

“House officers deal with me as though I am one of them because I take the time to discuss with them patients’ cases and not just limit my work to the tasks they assign me. I put effort in trying to get the most out of the internship experience and not just wait until I am given instructions. This does not only benefit me but it also makes house officers feel that I am a real help to them and that they can rely on me just as though I was a house officer like them. It is also useful to everyone, including patients if one tries to not accept the system as is but negotiate things. For example, once I took a patient’s case to the employee who registers it to be admitted for operation, but the quota of the number of patients that can be admitted for the day was fulfilled so he would not take it. The norm is to wait for the next day and take the case again but instead I argued with the employee. I asked him nicely to take the case now and admit it when the next day quota re-opens... instead of going and coming back again and risk the possibility that I might find the quota fulfilled again and then the patient would just wait longer.”

This quote is interesting because it does not only regain faith in the ability of benefiting from the system that is often criticized by interns but it also shows ways of negotiating with it. While many interns, as he explains, take it at face value that the structure of the institution is as such, he explains that with some negotiation things can actually be done better. However, such negotiations, I argue, are not always successful especially the ones that demand a more structural change, as I will show in following chapters with other requests made by interns from the university institution.

Apart from individual trials to make the best of the intern experience, the intern year in general seems to be the time when students experience their first disenchantment with their role as doctors. Although they have been taught throughout their six years of study how important the role of the physician is, the first practical experience they receive engenders feelings of insignificance and worthlessness. In the specialized department they either do nothing or

transport material, and in the ER they are faced with cases that make them realize how much knowledge and experience they lack. Some of them pointed out with humor that the image of the doctor is all they have. For example, when I wanted to join them to the ER they asked me to wear a white coat so that no one asks me who I was and would assume that I am an intern like them. When I explained that I would not want to do that because I would then be lying, one of them said jokingly "Believe me we are also lying wearing this white coat" indicating that they lack the knowledge and skills to be considered medical doctors.

The interns' view of themselves, as worthless and insignificant, seems to also be shared by others at the hospital. In one of the interviews conducted with a professor at the hospital, she said that interns among staff and faculty members are commonly named "hyperactive, nonproductive, white coated, blood carrying organisms...they do nothing all day but transport blood and hang around at the cafeteria". Hanging around long enough with the interns at the cafeteria, one can even forget that it is a hospital, except for a few signs that act as reminders. For example, the cafeteria is called Maxilla (a fusion of two bones along the palatal fissure that form the upper jaw) and the interns are sometimes wearing white coats or scrubs. Moreover, at a certain hour of the day patients' relatives and friends come to visit and then one observes a lot of patients with their relatives around the cafeteria area. Occasionally ambulances stop near the cafeteria area to drop off patients and one can witness occasional talks among interns about patients or "cases" they are dealing with.

With so much time on their hands interns sometimes play games. In one of the night shifts I spent at the hospital I played cards non-stop with interns for about 5 hours and we even ordered food. Spending so much time in a hospital without actually getting involved with patients may

lead one to even forget the larger context that surrounds. The cards game was held in the interns' resting room; a small room about 20-25 m² that contains huge bags of old x-rays thrown on the floor, a bed, a table, 4-5 chairs, a fridge that contains blood bags, and a bathroom. The room is dirty and dust covers the floor, tables and chairs. The bed sheets seem not to have been washed for months. However, the room over-looked a beautiful view of the Nile with fancy boat-restaurants and yachts parked at its shore.

On the other hand, before entering this room, one passes an alleyway that is as dirty as the interns' resting room but that has about 20-25 people in shabby clothes lying on the floor, some of whom are covered with blankets as unwashed as the ones observed before. When I asked who those people were, fearing that they are actually patients, I was comforted by one of the interns that they were not patients but relatives of patients. Although the information was not as comforting as the intern wished it to be, I was relieved that they were not patients who had to sleep on the cold dirty floor, but "only" their relatives. What I did not expect, however, was that I was not the only one who was not a hospital worker to join in the cards night. A banker friend of the interns seems to have been doing that throughout their 12 months of internship. The interns, obviously, were not the only ones who were habituated to the situation. Their banker friend also seemed accustomed to the sight of people lying on the dirty floors and of injured patients being rushed in through the hallway. In other words, you just needed to be there long enough to get accustomed to such sights since they have already been so normalized by everyone around.

However, processes of normalization and habituation take a while for interns to internalize. Interns repeatedly tell stories of their first few months of practical training, especially those who

had to start at the ER. One intern for example said "My first three months were in the ER...I got so shocked with the situation...I lost about 10 kilos...I got into severe depression."Others explained that they knew about the situation from before and some of them even attended the ER with friends before having to take shifts there, so as to prepare themselves for a lot of was yet to come and to gain experience before hand, as to how to deal with admitted cases. The shock for the interns was not limited to their inability to fully help patients, but also to the general condition, namely the lack of equipment. The lack of equipment at the hospital makes them a rare resource, most evidently marked in the role equipments play in power negotiations.

Many interns complained that apart from the fact that patients need to buy much of the equipment and medication that is not provided by the hospital due to lack of funding, the doctors themselves often lack basic equipment necessary for their work, such as gloves and masks. This lack, complained one intern, does not only compromise the patient's treatment but the health of physicians. She said:

"One patient who was known to be HCV positive vomited blood all over me...I was wearing nothing for protection and I was completely covered with his blood...all I could do afterwards was wash-off the blood covering me with water."

What was different from most of the literature written in English about hierarchies within hospitals, mainly in Europe and the US, is that nurses seemed to exercise a lot of power from this shortage. Interns complained they had to negotiate with nurses delicately to access resources, or nurses would ruin their work. House Officers could burden the interns with responsibilities but would not do that with nurses. They reported that nurses were the ones who controlled the

distribution of equipment and they could simply claim there is none available. An intern elaborated:

one night we got this emergency that needed operating and the nurse just said that her shift was over and that she is waiting to hand in the shift to the other nurse who had not come yet and she did not provide us with gloves. We operated that night without gloves because we could not leave the patient...looking back now we should not have done that...it was very dangerous...we were operating on a patient who was cut open without any protection

Although theoretically nurses fall at the bottom of the medical hierarchy, they seem to have considerable power over physicians whether interns or house officers. According to the interns, even professors had to reckon with nurses. All interns interviewed said that if professors were not careful with how they treated the nurses, they would ruin all their work. An operation cannot be successful if the nurse decides to ruin it for the doctor, said most of the interns. Furthermore, some of the interns believed that nurses also stem their power from their relation with professors, which they gain over the years. Interns on the other hand do not have such a relation to the professors since their 12 months stay is transitory and temporary.

Talking about nurses, interns often articulated the class difference that separated them from the nurses. However, they formulated it in such a way so as to indicate that they find it hard to deal with nurses because of their social background. Some of the interns said that apart from the fact that the nurses control the equipment, they find negotiating with them difficult because of the nurses' ability to fight and smart-talk them. Hierarchy here takes two dimensions, one of profession and another of class. The interns express their dissatisfaction with the amount of power nurses have over their work, even though theoretically the doctors should have more control than the nurses. They are also met with the dilemma of having to gain fighting skills reserved for a particular social-class, although they perceive this class to be lower than theirs.

Against all their expectations, interns learn through their first year of practical training that the doctor's authority to influence and control is considerably low. Several of those interviewed confessed that they used to believe that the doctor is supposed to have the final word when it comes to the choice of treatment and the way by which it is provided to the patient. However, what they realized is that a lot of structural and material barriers influence doctor's actions. For example, an intern explained, if there is a doctor that has the skills to treat a particular patient but this particular patient is not assigned to the doctor's department, the skilled doctor does not have the right to treat the patient even if he/she wants to. In that sense the intern believed that the structure of the hospital sometimes gets in the way of the patient's interest and the doctor's ability to give treatment.

Interns often complained about the hierarchy of the hospital. In a focus group interview conducted with 6 interns, they discussed how they found it very confusing as to whom to listen to when taking a medical decision. They were discussing that they might think one treatment is better for the patient but then get instructed differently from the house officer and sometimes even get a third instruction from the professor. When I asked what they did in such a situation, they explained that it varied. Sometimes, as one of them explained and all seemed to agree, they would listen to the instructions of the house officer or professor who would give them a harder time if not listened to.

In short, while in theory the interns believe that doctors can practice full control over their work and patients, they realized that the level of choice they had is limited. Although the ethics and communication courses I attended seemed to imply that doctors have a considerable autonomy as to how to treat patients, the interns realized that neither they nor the patients have much

autonomy as such courses implied. Informal and formal power, hierarchy and structures often guide most of their medical choices. They negotiate all these to practice some level of autonomy, although the meaning of the latter is starkly different from the one they learned about in theoretical courses.

After a while interns seem to normalize such gaps between what the correct medical practice ought to be and what actual practice at Al Kasr Al Ainy entails. One intern explained:

one day a house officer wanted a patient urgently to be examined for the clinical round and he was nagging and angry, so I went and lied to one patient telling him that he will see this medical professor who will examine him for treatment although I knew that the professor will not treat the patient but is only using him for the lecture...I just told the patient that because he would not have agreed to participate in the round otherwise and the house officer was pressuring me...I felt bad doing that but that's how it goes here

Without justifying lying to patients, I would like to examine this quote more closely to understand processes of normalization and how they shape what is supposedly "autonomous practice". In clinical rounds, professors need patients who would agree to be examined for purposes of training students. However, patients who would agree to do so are not always available; so they have to be "found". The professor pressures the house officer to find a patient, the house officer would in turn pressure the intern to find a patient, and the intern would do what he/she can to persuade the patient. The professor has authority over the house officer and the house officer can file a complaint against the intern if he or she feels that the intern is not getting the job done. Consequently, the patient in such a story becomes the object on which power negotiations within the hierarchy are refracted, especially that patients have little mechanisms by which they can hold the hospital or a physician accountable.

Since interns have already normalized that hierarchy is a defining factor in their practice and that what they learn as “good quality medical practice” is not necessarily the practice that is applied within this university hospital, lying to a patient can pass as a “normal” practice. However, since there are also personal norms and values held by interns that can clash with the normalized practices within the hospital, feelings of guilt are often expressed. While the intern expressed that she felt bad having lied, she adds that this is "how it is here". Therefore, the university hospital creates norms that are gained through practice but that do not necessarily match with the theoretical values and norms that interns had as they entered their intern year or those that they still uphold outside the hospital.

The gap between official state discourses and practice is evident to interns as they start their practical training, and gets normalized as they approach the end of their training. Since most of the interviews were conducted towards the end of their training year, normalizations of most practices have already taken place and interns talk of such practices with no surprise. However, some do reflect on how they perceived such practices before and my presence sometimes reminded them of how "abnormal" such practices would be viewed by an "outsider" or someone who has not yet adopted the norms of the place. In other words, my shocks and surprises reminded them occasionally of themselves when they first started. For example, when I first saw the relatives of patients miserably sleeping on the dirty hospital floor, my shock was apparent to the interns and I got several humorous comments that made fun of my surprise. Interns seem to sometimes even take pride in having got accustomed to this situation because it shows that they are now "real" doctors, and they know what being a doctor here really means. In other words, acquiring such norms becomes a part of what defines them as physicians at Al Kasr Al Ainy.

Not all interns seem to accept that they are sometimes pushed to conduct "bad quality medical practice" but most of the time mechanisms of normalization develop, as discussed above. Mechanisms of normalization vary and black humor seems to be one mechanism used. For example, in one group conversation between interns they were joking about how often they use a certain spray on patients. This spray is supposed to be applied to the patient's nose to give him/her a burning sensation that would cause the patient to wake up if s/he had passed out. However, the spray is sometimes used, as one of the interns explained, with patients who seem to be faking illness. The joke went as follows; one intern asked others laughingly how often they use it and added that he does a lot. He continued to joke about the funny stories patients come up with and that makes it obvious that they are just seeking attention and do not have a real emergency.

The intern explained that for example a woman and her daughter came to him and the mother told him that she fell once and her daughter fell twice. The intern said that he did not understand and asked the woman to repeat what exactly happened and again she gave the same explanation. Consequently, he thought that she was just saying nonsense and had to give her something that would seem like a treatment but that would actually push her to leave, so he used the spray. Another intern also laughingly added that she also sprayed a patient who just wanted psychological attention because she was busy with so many other real emergencies and added that the patient got so shocked and immediately said that she was leaving but to make sure that she does the intern threatened to spray her again. However, a third intern interfered saying that this was wrong and that these patients just needed psychological help and a little comforting would do the job. Others objected that they had no time to comfort each patient

coming in since they had more important emergencies to handle. Still, the differences that exist between interns' views also show that normalizations are also often resisted.

Still, black humor may not only work to normalize 'bad medical treatment' but sometimes justify it, as when the intern joked about the "nonsense" story given by the mother who told him that she and her daughter fell. Often, different ways of explanation and even language, whether related to class, gender or ethnicity, may distort communication between patient and physician. Since patients are often from a lower socio-economic background than the interns, as often pointed out by the interns themselves, the language by which they explain illness is very different and often lacks scientific terminologies. It has been argued that not only does socio-economic background play a role in terms of patient access to health but also in how far the patient is able to negotiate aspects of illness and treatment with physicians (Fadiman 1998; Mullis 1995; Roter, Lipkin, and Korsgaard 1991; Ryn 2002; Davidson 2001; Fox and Stein 1991). Speaking the same scientific language as physicians can give the patient a lot of power in negotiating his/her health and illness. Therefore, in this context not only is humor used for normalizing "bad medical practices" but in justifying them through belittling patients' concerns and worries.

On the other hand, it needs to be pointed out that there is a realization that not all norms acquired at Al Kasr Al Ainy can be applied in other hospitals. For example an intern explained that treating patients in the ER without experience cannot be applied to a private hospital; she said: "Imagine if you go and pay a lot of money in a private hospital to get treated...you will not accept to have physicians experiment on you". Therefore, such norms acquired are not that of a physician but that of a physician working in a public hospital. Normalizing that patients can be

lied to, mistreated without accountability and even ignored for long hours until a specialist arrives seem to only apply to their current setting. However, as the intern's quote implies, in other settings being a doctor entails different norms. Although the interns can express some pride that they have grown so accustomed to such norms, there is some recognition that such norms will not be acceptable elsewhere, namely expensive private hospitals. Whether such norms also become part of their habitus, that they may unconsciously take them with them also to a private setting or not requires that a study of the private health care is conducted. However, for those who can reflect on such practices and explain that they may apply here and not there, it is hard to assume that such norms are habituated, but maybe they have been for others.

What seems to be habituated, on the other hand, is the commodification of the patient's health. While norms regarding the treatment of patients may vary from one hospital to another, the reason for its variation, namely how much is being paid, does not. Even when one analyzes the structures that shape the norms acquired in Al Kasr Al Ainy, one would realize that it all boils down to commodifying health, a concept so normalized that it is hardly questioned. Nurses gain their authority from their control of equipments, the equipments are scarce because they are expensive, the lack of equipment that affects the patient's treatment is related to its cost, the lack of house officers is due to the cost of hiring more, the use of interns in the ER instead of doctors is due the doctors' lack of time spent elsewhere that pays more...etc. Of course this is not the problem of Al Kasr Al Ainy alone, it can be applied in every hospital but upon which all other norms are established differently within each context.

Interns who have worked elsewhere often make comparisons and they explain how norms vary from one hospital to another. Al Kasr Al Ainy is said to be better than public hospitals that are

not university hospitals, but much worse if compared to a private one or let alone one in a developed country. Ethics that guide doctors in dealing with patients are often directly linked in interns' explanations, with how expensive or well funded the hospital is. Health of patients and the way they are treated are not the only things commodified, but also the intern's quality of education as well as their future chances, but more on that later.

Although commodification of health is nothing particularly new (Chiffolleau 2005; Shukrallah; Simon; Sabour, Hassan, and Shaalan), the extent of it seems to be increasing as the market becomes stronger. For example, while getting hired at Al Kasr Al Ainy used to be considered prestigious, despite of the hospital's quality, it no longer seems to be as much. Some of the interns explained that although they might have scores that are high enough to guarantee them a position at Al Kasr Al Ainy, they are thinking of declining it and travelling instead. They explained that if they are hired at Al Kasr Al Ainy, it would cost them five years of practice which means that they would be very old by the time they make money enough to sustain themselves or their current/future families.

One intern from the 6th of October university (a private medical school which send its students to get their internship year at Al Kasr Al Ainy) said that being a medical doctor is not as prestigious as it used to be for his father's generation. He explained that his father insisted that he would study medicine instead of business, no matter how much money he needed to do that, because he believed it to be a prestigious profession. The intern, on the other hand, explained that his father is thinking with an "old" mentality, and expressed his frustration that he would only start "making money" after years of studying and working while his friends who work in banks, on the other hand, are already married and can sustain a family. He added that a friend of his working in

a bank makes fun of him by saying “*bokra enta hateb’a doctor add el donya*”, an Egyptian expression often used by parents and family members which means “tomorrow you will be something big working as a doctor”. The ironic tone in which the sentence is said implies that his friend believes that he is old fashioned still waiting all these years for “becoming something big” working as a doctor while he can make his money quickly through business.

To sum up, interns as they get into their first interactions with patients realize that what they learn as “good quality medical conduct” cannot apply in the context of Al Kasr Al Ainy. Since they lack faith in the hospital institution, they make no demands of it but instead they try to get accustomed to the situation. Those who still make demands of the institution are often met with no response from hospital officials. Hence, interns engage in normalization mechanisms by which they learn to accept and sometimes even justify not abiding by “good quality medical conduct”. By normalizing their incapacity to abide by good quality medical conduct, interns also normalize and learn to accept social and economic structural barriers that lead to this incapacity.

While the “old” state rationale seems to differ from the ‘new’ state rationale in recognizing political and socio-economic structures, still, the naturalization and marginalization of the socio-economic structures that shape medical conduct seem to have been in process for a while. The importance of intern signatures over equipment-availability, and the existence of the private sector besides the public even before the *infitah*, shows that socio-economic structures were not a priority in how quality was assessed even before the application of the accreditation criteria. In other words, the normalization processes of political and socio-economic structures have been part of Al Kasr Al Ainy culture for a while, proved by the absence of any criticism of the courses’ content. While interns expressed that such courses would not improve quality, their critique was

not directed to its content but rather guided by their lack of faith in anything provided by the state university institution. In other words, the discourses that marginalize and naturalize political and socio-economic structures are a continuation of older discourses and are not necessarily completely new.

What seems to be changing, on the other hand, is the extent to which the market is playing a role in the commodification of health. A concept so normalized, as explained above, is that health is a commodity. Still, there used to be more room for a welfare system that provided for the poor, such as Al Kasr Al Ainy, and that could still compete with the market in its prestige as an institution which doctors would seek to get employed in (Chiffolleau 2005). However, as the market also creates new professions that require less effort and time but provide “fast money” to meet the growing “needs” of the market, interns find themselves less tempted to seek employment at the institution of Al Kasr Al Ainy and often compare their “unfortunate” situation as doctors with friends who chose the path of business.

7 Differential socialization and choices (gender, class and religion)

The gap between what *ought to be* and what actually *happens* at Al Kasr Al Ainy is not only limited to intern-patient interaction, but also to other aspects of the interns' learning experience. Class, gender and religion seem to be three differentiating factors in the interns' experiences. Although all interns are officially considered equal in obtaining the same training, experiences differ along the lines of class, gender and religion.

Class

Interns expressed a lot of frustration related to the number of years they needed to spend studying. Although starting their intern year they are supposedly hired by the state, the salaries they earn are extremely petty. Therefore, not only do medical students need to find external sources of financial support throughout the six years of medical learning, they also need to spend another year as interns followed by five years as house residents. Ultimately, it is those whose family assets can support them for so long, who can study medicine. However, medical students from less privileged backgrounds work outside Al Kasr Al Ainy, usually starting their intern year. When I asked where they usually work, they explained that pharmacies or pharmaceutical companies are usually the choices available. Pharmaceutical companies, they explained, use interns to market their medicines. The implication of such work on doctors' biases of course needs a lot of research, but is beyond the scope of this study.

What was made obvious throughout my research is that interns' socio-economic background has many implications for their experiences as students of Al Kasr Al Ainy. Students from a relatively less privileged socio-economic background do not only need to find work, but also have a harder time funding private lessons and other “skills” necessary for their training. Since most students have to turn to private lessons to get a good enough education to pass or earn high grades, the state education sector which is supposedly free really is in practice premised on unequal access. According to one interview, the cost of one course goes up to 2000 EGP, which is 10 times more than what the students later earn as interns per month.

Private lessons are not, however, the only expense during the medical educational years. In practical exams, for example, when students are expected to examine patients, they also have to pay, but this time to the patients being examined. One student explained

I could not believe that I enter to examine the patient and he has all the answers ready for me for a case I do not know anything about or did not put effort in finding about...if you do not pay him in return for information he can do things to make you fail...give you wrong information about his symptoms.

In other words, there are "professional patients" who live off being tested and who get their money from students who want to pass their examinations. Students have to pay for many things and while such expenses for some may not be much of a burden, to others they are. Even for those students who do not have to pay fees and are enrolled in public universities, they still have to pay for private courses, books and tests. Additionally, for those students who did not attend private language schools, foreign language skills need to be acquired which also need additional paid courses.

Apart from all these expenses, students need to look "presentable" in-front of professors during oral exams. In other words, they need to be dressed up in relatively expensive clothing. They are recommended to go for study abroad semesters, which do not only require that they afford the complete costs of the trip and accommodation, but that they also pass the interviews. The interviews for traveling abroad, according to several interns interviewed, only focus on the student's fluency in speaking foreign (read: European) languages and his/her socio-economic appearance (e.g. clothing, language, manners...etc.). It is important to note that what is considered to be a socially presentable appearance is that which seems to look closest to a "Western" one. The ability to speak a European language, preferably without a strong Egyptian accent, is one example.

It is usually those who have obtained an education affiliated to the West, for example attended private International "language schools" or those who have acquired such social appearances and skills through their family, are the ones chosen. Consequently, it is more likely that those who come from a rich background are those who travel abroad, add that to their CV and make connections with Western countries. This is very similar to how Chifolleau described the state of medical education under British rule, where doctors needed affiliation to the colonial metropolis through western language, dress, connections and social behavior to maintain certain privileges in their career, and it was those who were already rich who could afford doing that (Chifolleau 2005, 76-80).

Money and social background notwithstanding direct personal connections also matter. "*Wastas*" (personal recommendations) channeled by family members and acquaintances, help in enhancing students' scores and career potentials. Sons and daughters of medical professionals,

upon such *Wastas*, receive preferential treatment, especially during examinations. Not only do such connections influence scores, but also future choices. Different future choices are mostly reflected in specialization choices. For example, surgery is mostly chosen by students who can either get training within the hospital of Al Kasr Al Ainy, and these comprise the highest 150 scores, or can train with family members in the field of surgery. Since a very limited number of students get grades that are high enough to qualify them to train at Al Kasr Al Ainy, and even those are not guaranteed assignment in the surgery department, it is mostly those who can get training with family or acquaintances that are likely to choose the field. Surgery, however, is a highly desired field because it is known to be financially rewarding.

Cardiology is another financially rewarding field, but in addition to personal connections, it requires that students know they can establish a private clinic. When interns consider their future options, their financial capacities also often shape their choices. For example if an intern is considering traveling for some years, as most feel necessary if they were to "build their name in the market", money and connections play a big role. Interns explain that to travel to the US (the most preferred destination) they need to take several tests and each test costs money. The same goes for the UK and the rest of the EU. However, some students travel to the gulf countries to make some money and also get training. Chifolleau explains that even the choice of country differs according to socio-economic background. She explains that those from the less privileged socio-economic backgrounds are those who choose the gulf countries, for it is easier to travel to and it gives them the chance to make money regardless of their connections. However, those who travel to the US or the EU are usually the richer ones who have the money to enroll in the required courses and examinations. Furthermore, opening up private clinics is not unique to cardiology alone, as mentioned above. Almost all students interviewed plan to either open up

private clinics or work in private hospitals. Even though not all have the means to afford opening up their own private practice, they plan to work towards it. Even for those who want to work in radiology for example and do not need a private clinic, most opt to open up their private labs and centers.

In short, the family's financial abilities and social connections play a role in how the student is socialized to become a medical doctor and what s/he is exposed to. Students from lower socio-economic backgrounds are more often exposed to working in private medical industries and pharmacies, while the richer are more exposed to getting advanced training in private clinics and hospitals abroad. Those who are not well connected are more likely to have to work harder than those whose family members are in the medical field. Therefore, connected students have a higher chance of getting the highest scores and getting a position at Al Kasr Al Ainy. Richer students who have a higher chance of getting high grades are more likely then to get assigned (*takleef*) somewhere in or near the metropolis where private practice beside civil service is more financially rewarding. However, class is not the only factor that differentiates the experiences of students but gender and religion also play a role and interact with class to shape the student's experience of becoming a doctor.

Gender

Although gender differences in some respects are more challenged in a hospital setting than elsewhere, differences still play a role in how students experience Al Kasr Al Ainy. Gender, like class, creates differential forms of socialization. Al Kasr Al Ainy allows both genders to get in closer contact, a practice that elsewhere in Cairo may seem inappropriate. For example, many of the female interns doing night shifts are otherwise not allowed by their families to be out of the

confinements of their homes after a certain hour of the night, let alone socialize with male acquaintances and friends. At Al Kasr Al Ainy, male and female interns socialize all night long either by working shifts, spending time at the cafeteria, or simply hanging out in the interns' resting room. Some girls explained that although when they first started their night shifts their parents were a bit worried and would call them every hour or couple of hours, they later got used to it and stopped worrying or calling as often.

Analyzing some of the male doctors' comments it also seems that some of the stereotypes get diluted by time, at least when applied to the female doctors working with them. For example, when I asked one of the male house residents if I could attend an operation with him, he asked whether I could take it and added that being a girl I might not tolerate the atmosphere. When I asked whether there are no females working in surgery, he replied "girls working in here [the surgery department] are no longer girls, they become like us". While the house-officer did not discard the gender stereotype he has about women, namely that they cannot tolerate a "harsh" atmosphere, after years of working together with female doctors, he considered them (the female doctors) to be just like one of them (the male doctors). Such a quote shows that the male house resident probably does not view his female counterparts as any different or any less competent for the job.

Still, women face some barriers alas not from their male counterparts, as far as I have observed. Safety during night shifts is an issue women often discussed. When I attended my first night shift and as I was leaving Al Kasr Al Ainy, three male interns asked to accompany me to the street so that I would not have to walk alone through the dark park. I was surprised at the interns' concern over my safety, for I thought that a hospital is necessarily a safe place. However, they

explained that it was not. The hospital's actual safety is not the problem here but rather their perception of its safety. The interns' perception that the hospital is not a safe place for women to walk alone late at night is enough for women interns to have their movement controlled.

One of the female interns explained to me the next day that the dark out-door areas of the hospital are spots for rapes and burglaries. Again, they could name no actual reports of such incidences, but rumors seemed to roam among interns. The same female intern told me that women-doctors face a problem during night shifts when they want to go and get blood bags from the blood bank. The bank is far from the emergency room and to get to it one not only needs to pass the dark park but to also pass a dark in-door hallway and go up one floor. Women are afraid to go through this road and have their male counterparts do the job for them during night shifts.

When one of the woman interns requested from the head of the hospital that they be provided with lamp posts in the hall ways and parks for safety, she was met with what, according to her, was an 'unimaginable' answer. The answer was that instead of providing lamp posts he will provide a male doctor for every female doctor working at Al Kasr Al Ainy. The absurdity of the reply allowed it to quickly spread among all interns. They all seemed to have received the statement with some amazement. Several women informants during different interviews repeated this statement to me and always referred to this particular female intern who made the demand and asked me to talk to her to make sure the story is not a rumor but a "fact". The amazement of the interns and their description of the reply as an 'unimaginable', shows that although they may have normalized that male doctors will do the job during night shifts, they did

not expect that such a situation will be officially articulated, not even as a joke. For the head of the hospital to joke that officially the hospital will assign each female a male to provide her with protection, meant that he has normalized the situation to the extent that he has “officially” accepted it. While they normalize many things that go against what they theoretically learn, they do not accept that officially such a gap, between what “should” be and what “is”, is made “official” (i.e. recognized by an authority). In other words, narrowing the gap between discourse and practice, by officially accepting that females are dependent on males, was unaccepted by interns. In other words, interns in such incidences liked maintaining the gap because they preferred what the discourse offered as opposed to their daily reality. Rumors were not all that women interns expressed concerning safety. One Woman intern said:

one day I was passing by the dark hallway coming from the blood bank at night and I had two blood bags with me...I thought to myself what if someone attacks me and steals the blood bags...they cost a lot now...how much do they cost? Each would cost about 300-400 EGPs.

Although the intern here does not refer to the rumors often mentioned by others, she claims there is a reason for her to be afraid. She explains that walking in a dark long empty hallway that anyone can enter (a public and security free space), where people know that doctors carrying blood bags (an expensive and rare commodity) often pass and with her being a female (a perceivably more vulnerable gender), places her as well as other women interns at a high risk. Perception of safety is very important here and the factors that change such perceptions are also important. A Blood-bag is not just an object, it is an expensive and rare commodity just as being female does not only imply the sex of the intern but the gender differences that come with it, in this case differences in vulnerability. Such connotations whether attached to the object of a blood-bag or the female intern play a role not only in the interns' perception of safety, but also in

her actual safety since such connotations are shared by others who physically pose a potential threat. Consequently, female interns face a potentially higher risk even if the rumors of high rates of burglary and rape are inaccurate or purely false. Either way, women professionals working night shifts are in some respects dependent on their male counterparts and it was made obvious that no efforts will be made by the hospital to change the situation.

Instead, “unofficial” (i.e. not the hospitals' or the managements') messages are often sent to women interns as to how, as women, they should or can protect themselves. Visiting the women's dormitory, I observed several posters and stickers on the walls asking women to wear loose-fitting clothing, get veiled, give up makeup and give up wearing perfumes. All the advices implied that women should try and look less attractive to men. While such messages were primarily religiously backed-up and explanations to why women should follow such dress codes mostly referred to religious texts, they also tackled the safety issues that seemed to threaten women working at the hospital. For example, such a dress code is also meant to provide women with more safety, at least regarding rape. In short, the individual woman doctor was made responsible for her safety. Since the hospital shows no signs of at least intending to change the situation, changing individual habits and tactics are offered as a solution.

Using Gramsci (Gramsci 1971), one can conclude that in these areas of civil society where the state leaves gaps, other competing groups will fill them in. In this example, the state (symbolized by the head of hospital) did not show any intention of providing safety to women. However, religious political groups provided alternatives that did partially solve the problem. Here I am not implying that the need for safety is all that drove such groups to recommend the veil, but I am showing how groups competing with the state may provide what the state fails to. By filling

many other gaps, not just this one, political religious groups push forward their competing ideas. The spread of the religious discourse can be analyzed not only in a Gramscian sense but more in a Foucauldian one, where it is normalized and created through daily practices and power relations (Foucault 2008). As one Christian intern explained: "They [the political Islamic groups] do not preach religion as such, to them it is a way of life that they establish"

It is in the daily practice that the discourse is established. As the intern quoted above observed, religious discourses gain their efficacy through such daily practices and relations. However, while the religious discourse here gives an alternative to depending on the state institution, by providing women with a solution, they foster the state's discourse which tries to shift responsibility from its institutions to individuals. On the other hand, state institutions and agents do not fight religious discourses when they tackle such an issue of individual habits and dress. On the contrary, they may even foster it and support it. Some state agents may also even use the religious discourse to again compete with political religious groups. In this context both foster the individualization of responsibility and put it in women's hands.

Finally, just as class plays a role in what students choose for their future careers, gender also does. Many women interns explain that women tend to choose psychiatry, pediatrics or radiology because they are less demanding than other specializations that involve more emergencies. Several times, women interns would say that for them it is better to choose something easy so that they can care for their future or current families as child nurturers and home-carers.

Religion

A Christian intern, also quoted above, explained that being a Christian at Al Kasr Al Ainy also means that certain specializations are not an option. According to him, Gynecology, Optometry and Orthopedics are not opened to non-Muslim students. Although no official law or policy says so, it is informally acknowledged that Christians are pushed out of these three specializations. When I asked how, the intern did not specify, but said “hayetqasoh” which literally means they will be “cut out”. “How will they be cut out?” I asked, and the intern just replied that they will be socially and indirectly pushed to leave. However, he added that the Optometry department has lately opened up and that since the only Christian that teaches in this specialization is leaving, someone might come instead of him. It is also well known in the medical realm that Christians who want certain specializations need to travel abroad, and Gynecology is especially well known for that. Upon returning to Egypt, Christians working in such specializations either open up private clinics or work in Christian owned and dominated private hospitals. This also means that Christians escaping from such discrimination need to be rich enough to travel and go for private practice.

Furthermore, the intern who complained about discrimination within certain departments also explained that during oral exams, Christians particularly need a 'Wasta' to pass. While all students prefer to have 'Wastas' during oral tests, Christians feel they particularly need it. Even with such *Wastas* and no matter how well connected they maybe, they still have no chance, according to the interview, to get hired in certain departments. One story narrated to me by a relative in the medical field, concerned a Christian friend in medical school at an oral exam. The Christian student in the story was asked by his father “*why don't you change your shirt into something more presentable?*” and the student replied “*why don't you change your name first?!*”. Many Christian names stand out, and the sarcastic comment made by the son meant

that although appearances are important in how one is assessed during oral tests, religion plays a bigger role. Therefore, no matter how well dressed he was, the student believed he would still fail because of his Christian name.

Although the rise of the religious discourses in Egypt may have very well contributed to this type of discrimination, it is not clear whether it did. Still, there was an obvious tension in how the intern spoke of the Islamic religious discourse as he was describing the discrimination Christians faced. When he explained that Optometry was opening up, he added that it may be related to the decrease in the religious presence he has witnessed lately. I was surprised to learn that, since everything shows that if anything it is increasing. When I asked why he thinks it is decreasing, he replied “look around you...do you see any religious posters or stickers around...there used to be so many”. Although I did notice such posters and stickers in the women’s dormitory, I did not see any around the university hospital. Lately, the Muslim Brotherhood (MB), the main political Islamic Organization in Egypt, have faced a strong crackdown from the state. Fearing the coming elections, the state has arrested hundreds of MB activists as well as leaders. This blow faced by the organization maybe directly related to the decreased presence of religiously political posters within Al Kasr Al Ainy, especially that the faculty of medicine as well as the medical syndicate are well known for being dominated by the political Islamic group. Until now and even after the crackdown, the medical syndicate is still covered by banners, mostly Islamic, calling for the support of the victims of Gaza and the poor in Egypt.

However, the Islamic undercurrent is not only related to the presence of the MBs but has become an aspect of social life, even for those who are un-politicized or are not members of a particular organization. The Islamic religious undercurrent is present in the daily habits and

practices of many of the interns interviewed with varying degrees. The religious rationale dictates many of the interns' practices, not only in the medical field, but also in their daily social lives, regardless of their political affiliation. In a trip I joined to Al Azhar Park with a group of women interns who appeared more religious than others I interviewed, this became apparent. For example, several comments were made by the women about the immorality of couples hugging and holding hands in the park and no men interns were present at the trip. Several stops were made during the trip for them to pray and all of the 20 girls were veiled except for one in addition to me.

Although, political banners and actions may have been on the decrease, ways of living and dressing establish the presence of religion in the everyday at Al Kasr Al Ainy. Women's *Neqab* has been on the increase and the state's fear of the rise of the Islamic movement has led to the banning of this type of dress within universities. The ban has led to a massive outrage and discussions surrounding the ban predominated for weeks⁵. While some considered it to be a discriminatory ban, others argued that it was for the safety of the university. Several state agents argued that women wearing the *Neqab* threatened the safety of the university because they were unidentifiable under their veil. Furthermore, stories of women using the *Neqab* to cheat during exams were also often used to argue against allowing *Neqab* at the university.

Others, who were not state representatives, also had problems with women wearing the *Neqab*. In one of the clinical rounds, a professor (covering her hair) who also happened to be from the 9th of March Group (an opposition group of professors demanding academic autonomy) got into a tense argument with two of her students wearing the *Neqab*. Her concern was, as she

⁵ <http://www.shorouknews.com/ContentData.aspx?id=129980>

expressed to the students, that they could not possibly inspect a patient properly having their hands covered by gloves and their eyes covered by a cloth. However, one student answered her back in anger that she could still see clearly with what she was wearing. Three classes after this fight, the professor asked where these two students were, and added that she did not mean to upset them and asked the other students to ask them to come back and attend her lectures. The students' reaction shows that the issue has become a very sensitive one and a comment made about the way women are dressed was taken as an act of aggression. No doubt the state's ban and the attention given to the *Neqab* have given it a different meaning other than it being a form of religious expression. The *Neqab* became a symbol of defiance to state institutions. Consequently, the professor's comment was taken as an attack, whether the professor actually meant it as such or not.

Just as Christians are pushed out of certain departments, women wearing the *Neqab* feel that they are pushed out of the faculty. According to a professor at Ain Shams University, when students wearing the *Neqab* were not allowed to enter their exams, they wore the swine flu protection masks to cover their faces instead. Doing so, the management could not ask them to take it off, and they did not need to reveal their faces. Such an action was used to show the hypocrisy of the institution which, according to the students wearing the *Neqab*, is using safety as an excuse to fight the political religious discourse growing within universities and society as a whole, which often defies the State.

In short, religion shapes how students are socialized to become doctors in different ways. Minority religions, such as Christians, are discriminated against in an indirect manner, while growing political religious groups, face state and legal discrimination. However, closer attention

needs to be directed to the role of higher ranked personnel within the medical institution that may also be playing a role in discrimination against minority religions. The process through which discrimination is practiced need to be further studied. It is also important to note that, even though women wearing the Neqab are legally banned, they are still seen within the faculty and in the hospital which means that the banning law is not applied. Christian students who are not legally banned from getting hired in any department, on the other hand, are actually not present in certain departments. In other words, social discrimination seems to be more powerful in its application than the legal one.

To sum up, class, Gender and Religion are three factors along which differential socialization takes place. Other factors may be playing a role but have not been highlighted by the interns during interviews or observed by myself during my stay at the hospital. Class seems to be a defining factor, not only regarding how students are socialized, but also whether they will even become medical students in the first place. All interns seem to agree that one cannot consider becoming a medical doctor if s/he cannot afford a certain standard. Consequently, most if not all medical students belong to a certain class. Moreover, even within this class there are differentiations based on money, social appearances and behavior. Gender on the other hand, is also a factor that differentiates students' experiences. Just as class dictates future career choices, gender does. As richer and better connected students choose specializations that require capital and social relations, women tend to go for specializations that are "easier" and less time demanding so that they can also perform their gender role within the family as child nurturers and home-carers. Finally, religion plays a role in future choices since some departments within Al Kasr Al Ainy implicitly bar non-Muslims from entering. However, class interacts with religion to allow richer Christian students the choice to go for the barred specializations abroad and then

pursue a private practice. Religion also plays a role in grades, such as class does, but again overlaps with class to give better connected Christian students more chances. Furthermore, not being from a minority religion does not necessarily mean that religious discrimination is not a barrier. Muslim students face no barriers due to their religion until it takes on a political mode. Political Islam seems to be fiercely fought by state institutions and the *Neqab* has become a symbol of struggle within state university institutions, including that of Al Kasr Al Ainy.

8 Believing the imaginary

Although interviews with interns reveal that they have little faith in the government and hospital institution, one can still observe that, to a certain extent, they adopt the 'new' discourse propagated. While official institutions seem to have little hegemony, being constantly criticized by interns, aspects of their "new" discourse is to a large extent normalized and accepted. Interns tend to frequently criticize the state's education and hospital institution and express their lack of faith in it, while in their daily practices and norms they adopt much of its new rhetoric.

When asked about the new courses on patient-doctor interaction, although the interns revealed as they talked about their experiences how detached the content of the courses is from their practice, they did not articulate that as they were being interviewed. The only two things interns criticized about the courses were their timing and the format in which they were taught. All interns interviewed seemed to agree that the format of a lecture was not useful and that they would have rather taken the course as a workshop where they would practice different scenarios on how to deal with patients. However, they expressed their need to have gotten a practical training as to how to apply what they learned during interaction with patients. Practicing different scenarios would have, according to some interns, given them a concrete idea how to apply what they learned.

Most interns at Al Kasr Al Ainy seem not to question the feasibility of the courses' content but rather how they are taught, and demand that they are guided on how to apply them. Most interviewed seemed inclined to believe that if they were just properly trained how to apply such ethics, they would be able to. This shows that the state discourses that argue that only with

some “good will” doctors can practice ethical medical conduct is accepted but faith in the state's willingness to properly apply such ethics is what is in question. Furthermore, when material shortages are discussed as sources of unethical conduct, corruption within the state institution often gets the blame rather than the socio-political structures and discourses that defend them.

The state seems at first to have little hegemony. There is a general tendency for interns to see every action taken by the hospital institution, representing the state, as an “act” to cover-up for what they see as its failure. There were several examples that interns gave apart from the courses that seemed to imply this belief. For example, they explained the new set tests to be completely irrelevant to what they have learned or to what they practice during their internship and say that the proof for that is that the 2nd best student failed them. While the purpose of these tests was to assess the quality of practical experience students gain interns believed that the assessment mechanisms did not reflect reality and only emphasized the failure of the institution and its ignorance of the real situation, representing most state institutions. However, while loss of faith in authority is often articulated, the ideas propagated by some state agents and regulations do not seem to be in question at all. Interns do not see the courses to be essentially inapplicable and believe that only if the institution really wanted them applied, they could train the interns better. This view is identical to that articulated in the course which argues that only if interns had the intention to apply these ethical modes of conduct they would. According to interns, it is enough for the institution to “really” want to better their learning for such ethical conduct to be applicable, it just does not want to because it is corrupt.

What is important to note here is that the failure of the public education and health institution articulated by the interns, does not necessarily imply that the state has lost hegemony, since

such a critique is actually an essential part of the “new” state discourse. Emphasizing the failure of the state service institutions have been part of official state rhetoric ever since the early 90s, as mentioned above. Therefore, while interns express their loss of faith in state institutions, that does not necessarily express loss of faith in the state as a whole but only its role as a service provider. While some interns may generalize the state's failure beyond services, most do not.

In addition, most interns blame the state’s inability to provide a good public health service on its corruption, rather than on its inability to fund it. While the current government argues that the state simply cannot afford funding public services, most interns believed that the money went to corrupt state agents. Critiquing state service institutions is an indicator that the ‘old’ rationale that held health as a right through public services has been successfully undermined. Hence, state institutions that supposedly still represent this “old” rationale, namely state service institutions, and that are also viewed as corrupt, are those that are losing hegemony. The neo-liberalist discourse, which is part of a more global type of governance that is developing even beyond state institutions, is gaining ground. Therefore, state institutions and officials that articulate this “new” discourse are still to an extent influential. For example one intern explained that although the Minister of Health (a propagator of private health care and a former WB employee) was trying to change things to the better, it is hard because corruption is dominating.

As the new courses are part of a wider mode of governance that operates through international standards and accreditation of control, they are not criticized for their content. The state institutions that apply these courses and the ‘old’ public service sector that they are applied in get the blame for their inapplicability. I do argue, however, that state hegemony in general is weakened by the gaps that exist between discourses and practices, which create a lot of

inconsistencies and build towards a general disbelief of any official state action or statement. Nevertheless, when the same discourse is presented through civil society channels that are less related to the state apparatus, they are more accepted. For example, as the state's new health insurance proposal is discussed through media channels, that are not always state controlled, as well as international bodies such as the WB and USAID, they are more likely to be accepted. In addition, when state agents work through so called "NGOs" they are more likely to be influential (see chapter 9).

State corruption is the only critique ever given to justify why such a gap between discourse and practice exists. The example of the ethics courses demonstrates that clearly. While the students realize that such ethics are just not applied in their daily practice, they do not criticize the concepts taught as unfeasible due to the structural barriers that face them but they tend to believe that if only they were taught how to properly apply them they would work. When they do realize that shortage of material may lead them to act unethically, they blame this shortage on state corruption rather than on the overall socio-economic structures that lead to the setup of health care as it is. Here again as corruption gets the blame, the problem is individualized in particular state officials. The problems are usually related to corrupt individuals within the institution and sometimes even to patients who would rather not pay this little fee and would over burden the ER instead. Just as the state discourse puts responsibility on the individual so do the interns. Corruption seems to be a more acceptable blame rather than putting the blame on the system itself, because individuals can then be held responsible. Why such individuals are corrupt or what leads them to be so is not questioned.

Consequently, the “imaginary” created by the new courses can be believed because its failure is not blamed on its content but rather on those that apply it and on the institution it is applied within. If, however, new institutions are created and are run by corruption free individuals, usually non-state actors since state actors are corrupt, the imagined may come true. Structural and material barriers to good health care will remain an issue, but such barriers have been normalized and are not discussed as the main problem. Main problems relate to institutional state corruption and corrupt individuals, socio-economic barriers to “good” health care services can however be overcome by “good willing” individuals who will find a way around them. In fact, charity and voluntary work play a big role in interns' daily experiences of trying to overcome such structural barriers to good medical conduct.

9 Alternative institutions

Although the gradual dehumanization is an integral part of medical socialization, mentioned not only by literature on the issue but by the interns themselves, human empathy is still a big part of medical care that seems to be overlooked. Actions of altruism and human empathy are also present although unnoticed in the midst of the inhumane conditions that often dominate the medical field. However, when structural barriers to ethical medical care are normalized and unchallenged by the dominant discourses, alternatives to fill the gaps left behind are created. Most prominent alternatives noticed during my observation at Al Kasr Al Ainy were religious charity and voluntarism. Religion particularly seems to play a big role in filling in the gaps left behind by the system to offer a more ethical and humane form of medical-care and service. Local and international Non-Governmental Organizations (NGOs), religious and secular, play a role in filling the gaps left behind by the existing system. However, alternatives do not question or challenge the socio-economic structures that shape the medical health care system as is, but only work to provide solutions within it.

The sight of extreme poverty dominates Al Kasr Al Ainy. Not only are the buildings shabby, empty and dirty but the patients and even some of the medical staff give the impression of poverty. Beggars roam the hospital asking students, interns and doctors for money. Doctors' cars entering the university, on the other hand, reflect the social and economic gap between some of the doctors and students on the one hand and the patients that seek medical care on the other. The wheelchair that transports patients looks like nothing more than a piece of iron bent to appear as a chair, the same can be said of the beds. Sheets used to cover beds and patients look old and

sometimes even unwashed. Some patients or their relatives are observed sitting on the floor of hallways and on the edges of the hospital windows. On my first day, there was a woman sitting on the floor in-front of a doctor's office crying that her daughter was kicked out of the hospital in the middle of the night, on the pretext that she does not have the papers to admit her to a bed. Shortage of beds seems to be a common problem and many patients have to fight for admission due to lack of space. Security-men on non-emergency entrance doors almost interrogate patients as they try to enter, only admitting them at certain hours and making it hard for them to be accompanied by relatives. During visiting hours, crowds of people are observed on entrance doors struggling to pass through the crowd to reach their ill family members.

Chaos also marks the place. Since the only way to describe the hospital is that it resembles a maze, as patients are directed by doctors to go here or there they are found roaming around lost. With no written signs or directions, it is impossible to find one's way around if one does not ask. Even interns who have been around for over six years still lose their way. As patients are struggling to get their x-rays, scans, analysis and tests, they are often going up and down the stairs and walking through hallways trying to find their way with little guidance. A common scene in the ER is that of an intern or a house officer directing a patient towards one x-ray room or another scanning department. As interns and house officers are in an already burdened enough situation they are often reluctant to give detailed direction every single time, and patients or their relatives are left to ask around in the midst of their emergency. As even basic help, such as finding directions, is not always available to patients, psychological support or comfort is hardly existent. However, interns still find times and ways to humanize the atmosphere for patients.

It is a common act for interns and house residents to collect money from one another to support some of the extremely poor patients that are admitted into the hospital. As the state has been increasingly cutting its funding to the health sector, lack of equipment is a common phenomenon and patients are expected to buy missing equipment and medication. Those who cannot afford to buy the lacking medical necessities are the most disadvantaged with no official body to turn to. Consequently, charity became an integral part of the hospital culture and donation boxes are present within all ERs. Stories of collective intern interventions are common and part of the intern experience. Several stories were told of patients who did not have enough money to buy the requirements of operations or medication and house residents would send interns to buy the necessary material for them from the collected money. One intern even claimed that one time they got a case that was too severe and urgent and could not receive direct medical attention for lack of space and equipment, so interns collected money and send the case to a private hospital that was more equipped. Such stories were common in interviews and most interns often expressed their frustration that they could not fully help the patients admitted because of the hospital's limited capacities.

Material support is not all that interns try to offer to patients in this deprived atmosphere but psychological support as well. Although interns often expressed reluctance to provide anything but bio-medical attention, some interns often stressed psychological support and comfort as an important lacking aspect that they try to add to the care they give. One female intern told me a story of a little girl who was admitted to the ER after surviving a car crash in which she lost all her family members. The little girl was a year old baby, the intern explained, and she was in a very critical stage but could not receive the immediate operation she needed due to shortage of space and medical expertise at the time she was admitted. The intern at a loss as to how to help

this little girl, who had gained her sympathy more than any other patient she had come across, the intern started reciting her Quran. Unable to offer help through the available bio-medical system, the intern turned to religion instead, as she believed that this would at least help the little girl die peacefully. To use Marx's classical quote "religion is the sigh of the oppressed creature, the heart of a heartless world"⁶ . Religion for many interns balances out the dehumanization process they go through as they are becoming medical doctors.

Interns often explained that they realize how much they have been desensitized and that after some time patients' stories do not affect them anymore. One intern also explained that sometimes she feels frustrated at certain patients because they are taking up space that may save someone else's life while they are going to die anyways. She added that she knows that it is very insensitive to think like that, but that it is hard not to *"if you know that this space is saved for this old dying man just because he was admitted first while it can be used to save someone who has a chance to live"*. Such a level of practical thinking when one is talking of illness and death reflects a high level of desensitization and dehumanization where patients are only treated as "failing" or "surviving" cases. However, it does also, I argue, express another level of human empathy, where interns are trying to make the most for patients in a place that suffers from extreme dehumanization and severe structural violence.

One intern, while comparing his experience as a trainee in a US hospital and his experience as an intern at Al Kasr Al Ainy, described being at Al Kasr as a more human experience. I was surprised to hear that with all that I am seeing, but then he added that at-least here he feels that he is helping poor people who would otherwise not find this help available. As for his experience in

⁶ <http://www.marxists.org/archive/marx/works/1843/critique-hpr/intro.htm>

the US, it was more like dealing with cases without getting involved in the patients' social problems and details. His comparison was very interesting especially when compared with how Waitzkin explains the US medical system. Waitzkin argues that the US medical system tends to marginalize patients' social and economic concerns and only focus on the bio-medical aspects of their illness. According to the intern interviewed, Al Kasr Al Ainy offers a richer experience since it gets him involved in the social and economic aspects of the patients' case as well.

It is important to note that the socio-economic background of the patient does also play a role in how interns learn to treat patients. For example, all interns interviewed explained that from their assessment of the economic background of the patient, they choose one treatment over another. They explain that to patients who seem to be poor, they subscribe locally industrialized medications whose imported equivalent is much more expensive. Furthermore, they may decide not to ask for certain tests or analysis that are not urgently necessary if they feel that the patient may not be able to afford it and instead use more basic ways of diagnosis. To richer patients, one intern explained, physicians usually prescribe the imported and more expensive medication. When I asked whether the imported more expensive medications were better, the intern replied that it was not necessarily so but the patients' perception is important. *"For example",* she added, *"I saw my father, who is a medical doctor, prescribing to a patient in his private clinic a medicine...a couple of hours later after the patient had purchased the medicine which was for 3 EGP, he came in and asked whether this medicine would do anything because it is so cheap...he didn't believe it will work because it is so cheap".* Since poor medical care is related to low-cost medicine, as "structural violence" (Farmer 2004; Bourdieu 1998) is produced by such a mechanism of cost related medical quality, good quality medicine is related to high-cost medical care. Consequently, presenting medical care or medication as expensive can also play a role in

how it is marketed and accepted as a form of high-quality care. The implication of such perceptions on private medical care needs further examination but is beyond the scope of this study.

Back to religion, its role is not only limited to psychological support and comfort, but in fact most of the charitable actions take place through religiously themed organizations. Not only does charity within the medical realm take the form of donations, but there are hospitals and clinics that work purely for charity, of which most have a religious identity. Al Gameia Al tabeya Al Islameya or the Islamic Medical Association is one famous for providing health care for the poor. The idea, as stated on their website, is that by offering free medical care for the needy one can get closer to God through medical labor.⁷ The association offers services by providing several hospitals, clinics and labs for those who cannot afford health care. In fact, AlGameea Al-Sharaie is one of the Islamic NGOs that have gained mass support to an extent that was perceived as threatening to the government. The organization has 360 branches and three million members spread all over the country in addition to a clear ideological aim that calls for an Islamic state. It has frequently happened throughout its history, since its foundation in 1912, that organized political Islamic groups have infiltrated the NGO, used it to gain political ground and even won seats on its board of directors. Amongst these organized Islamic groups were Al-Jamaa Al-Islamiya in the early 1980s and the Islamic Brotherhood starting the early 1990s (Abdelrahman 2004, 140).

²http://www.bab.com/articles/full_article.cfm?id=5341

A lot of religious activism has been associated with providing health services and educational services to meet the high demand that the state is not fully covering by its public services. Abdelrahman explains that Islamic as well as Coptic NGOs have played a major role in health and education services that are increasingly left behind by the state. As the state has a strong grip over the sources of finance that goes into any organization through the Ministry of Social Affairs, religious organizations have an advantage of accessing funds that are not subject to state control. According to Law 32 any donations that are made to religious houses (i.e. Mosques and churches) are not subject to government supervision. Consequently, only religious NGOs can escape the complete control of state supervision by avoiding the financial control it usually exhibits over other organizations. Particularly after the *infitah (Open Door Policy)*, Islamic banks started flourishing and have contributed majorly to such NGOs through the share of the *zakat* (Abdelrahman 2004, 139). Coptic NGOs, on the other hand, have been increasingly gaining access to international funding channels, whether from individuals or institutions, and from the large and often well off Coptic community in the West (Abdelrahman 2004, 143).

This religious culture of voluntarism and charity seems to have strong presence within Al Kasr Al Ainy. As one intern was telling me of the different active groups within the university she mentioned a group called Student Health Awareness and explained that they are related to Sonaa Al Hayat which was first established by Amr Khaled. Amr Khaled is a well known religious preacher who first came out in the late 1990s and became known for his great influence particularly on middle class youth. Amr Khaled is also one of the symbols, according to Abdelrahman, of the Islamic consumerist culture that has grown after the *infitah* preaching that religion can be reconciled with the modern consumerist lifestyle (Abdelrahman 2006, 72). The intern then added that she used to be a volunteer in this group but that their work was made

difficult by the university hospital management because “*you know how they [the government] are afraid of the religious speech...so they do not really make things easy*”. Resala is another voluntary group that is well known for adopting a slightly religious approach to charity work. Interviewing one intern who used to work in Resala, I learned that her main work with the organization was with an orphanage beside the hospital. She explained that they took care of the children, spent time with them and those children who were believed to be exceptionally smart received funds from the organization to get the UCMAS (Universal Concept in Mental Arithmetic System) courses targeted at increasing child's skills and capacities. Other organizations within Al Kasr Al Ainy included Patient-Doctor New Era (PDNE), which aimed at getting voluntary interns to go around the hospital and make sure that each patient's case is followed fully by only one doctor, to avoid the confusion that usually takes place as doctors keep changing shifts.

The interesting dynamics of this voluntary work is that it becomes a continuation and a necessary part of the state social service and not necessarily a critique of the state's failure to provide the service. For example, Resala's work depends on collecting money to compensate for the lack of equipment which the state does not make available, but would never criticize its lack. On the contrary, it will add to the individual responsibility, already being propagated by the government, and would argue that if each individual would contribute a little, there will be no shortage. However, shortages continue despite of all the charity and voluntarism the university hospital receives on regular basis. Resala's approach to working with orphan children, on the other hand, is to provide them with international courses, like those that the interns themselves are continuously pushed to take to survive within the existing market system, but would never question whether these international standards of education are really increasing the children's skills or capacities, as they do not question that about the courses on ethics.

The same goes for the group working on student's health awareness, which gives the impression that lack of health awareness is the problem and disregards the unhygienic situations created by lack of equipment within the hospital which does not only harm patients but also doctors and mostly nurses. Many of the nurses' demands in their recent strikes were demanding compensation for their high risk of infection, as they are known to be the most prone to it. PDNE on the other hand try to implement a more personal connection with patients to compensate for the doctors' inability to follow up due to the high burden they receive, which gives an impression again that with some extra effort a better form of health care can be provided despite all forces. However, when I asked the intern who used to volunteer in this organization whether I could observe the work of the PDNE volunteers she said that they have not been working these days because of exams and explained that it is hard to continuously have the group going because medicine in particular is a very demanding study and students rarely have time. She added that most volunteer PDNE work can be witnessed beginning of the academic year when students are still not as busy. Consequently, patients may have an attentive follow up by volunteer students and interns if they are lucky enough to be submitted to the hospital beginning of the academic year, but unfortunate if they are submitted later, when students and interns are busy with other work. Still these groups not only make the state service function a bit better but repeat the discourse, now propagated by some of the state's institutions and agents, which holds that with some individual effort the service will improve.

Secular Non-governmental organizations, whether international or local, also play a similar role as that of religious voluntarism, especially when it comes to future choices of interns. Since most interns believe that poor people deserve to be treated, regardless of their capacity to pay or not, but still cannot survive on what the public sector pays to its medical employees, they are often

left with a dilemma. While most decide to work in the private sector, few try and find a middle way between serving those who cannot afford the private sector and their own interests. One intern explaining his future goal explained that he wants to open up an NGO which provides in one of its sections free service for the poor and funds it from the other for profit section. In other words, the intern wants to apply in his own private organization what was argued would work on the state's level but now has failed because of market forces.

The main argument here is that while religious or secular voluntarism, charity and NGO work give a more humane feeling to medical practice, they neither works against structural violence nor dehumanization processes that are inherent in the health care system today. On the contrary, some forms of voluntary work and charity organizations reemphasize the neo-liberal discourses which neglect social and economic structures that are causing daily structural violence.

As shown above, the mentioned groups are oriented only to compensate for the state's failure rather than question causes of structural violence. Interns learn to think individually, only thinking how as individuals they can both make a living and satisfy their human empathy at once. The Suggestion of opening up one's own NGO, which will balance both desires, is but one example of how interns can foresee their future as medical professionals. Other interns may choose to work in a private hospital or have their own private clinic and spare time for their voluntary work, as some are already doing as interns. All these options are possible. However, they all feed in the same 'new' discourses and strengthen it, by putting responsibility only on the individual.

To understand the role of NGOs, whether religious or secular, it is also important to note that the neo-liberal discourse. Amongst the important international bodies that have been pioneers in pushing neo-liberal agendas globally are those same bodies that provide for most of the financial base of NGOs in Egypt. USAID, DANIDA, Ford Foundation, the Netherlands government, CARE, and the Canadian government are the most active in the Egyptian context (Abdelrahman 2004). Islamic organizations, on the other hand, mostly do not receive funding from such bodies but from Islamic Banks, as mentioned above, Islamic International Organizations or Islamic Governments such as that of Saudi Arabia. It can then be deduced that the orientation of such organizations are not very far off from its donors of who most are proponents of neo-liberal policies, or at least of privatization.

While Islamic organizations and donors focus on concepts of charity to fill in the gap that is created by neo-liberal economic strategies, other NGO donors seek to individualize health issues to marginalize structural problems. As observed in Abdelrahman's study, many of the projects implemented by foreign funds did not reflect the needs of the community they were targeting and NGOs needed to tailor their projects according to donor demands. In the case of Health care, organizations expressed a need for building new clinics or getting supplied by essential drugs, doctors and nurses. However, donors wanted to focus on health education, training community leaders in preventive health care and communication skills and encourage the poor to seek medical help at available health clinics (Abdelrahman 2004, 184-185).

As Abdelrahman put it "these projects are based on the outdated assumption that the poor are not aware of the need to seek medical help in modern clinics and that they largely rely on traditional medicine and inherited customs" (Abdelrahman 2004, 185). In other words, the

poor's low health status is blamed on their "ignorance" and traditional customs rather than on the shortages of the health system. Therefore, the victims are held responsible for their deteriorated state of affairs and culture yet again gets the blame for the existence of poverty in health and well being. As Ferguson put it "the same processes that produce exclusion, marginalization and abjection are also producing new forms of non-national economic spaces, new forms of government by NGO and transnational networks" (Ferguson 2006, 38). This "government –by-NGO" (Ferguson 2006, 40) is usually the share of the poor who used to depend on the state which is now and has been for sometime withdrawing from its responsibilities. Through NGOs, religious and secular, the poor are now being governed.

Doctors who work for NGOs see that as a step in their career as they look for another job and usually also charge the patient higher fees than initially indicated by the organization to compensate for their low paid salary (Abdelrahman 2004). However, some of the religious NGOs pay higher salaries, even similar to those of the private sector, subsidize for the services and attract medical professionals who consider their work there as a religious duty and are more willing to work voluntarily. It can then be assumed that such religious organizations do not only act as alternatives to state hospitals for the patients but also for the physicians who want to serve the poor and also make a good living. State medical institutions, on the other hand, become "hollowed out" (Ferguson 2006, 39), as Ferguson put it as he was describing how former or current civil servants are drawn to the private sector leaving the public sector void (Ferguson, p.39). According to Ferguson the state itself becomes non-governmental, since its agents are drawn to private businesses and the "non-governmental" organizations come to be made up of current or previous state civil servants (Ferguson 2006, 39). These NGOs become the new

governing institutions through which state agents and international bodies operate and propagate their discourses, in this case to physicians and to the poor who seek health care.

To sum up, neo-liberal governance exerts itself through many channels and the state is only one of them. The state itself is not a coherent entity but one that is made of many institutions as well as state personnel whose roles and sympathies diverge and sometimes even overlap. State bureaucrats can sometimes also be or often are, according to Abdelrahman, NGO members or leaders, NGOs are influenced by some state institutions as well as international donors and some of the state institutions themselves are shaped by international donors and international political agenda (Abdelrahman 2004). Through these multiple and overlapping relations, neo-liberal governance is established. As Ferguson and Gupta explained, neo-liberal modes of governance do not only include strategies of discipline and regulation exerted by structural adjustment programs of international bodies such as the WB or USAID but also “transnational alliances forged by activists and grassroots organizations and the proliferation of voluntary organizations supported by complex networks of international and transnational funding and personnel” (Ferguson and Gupta 2005, 115). .

10 Providing the imaginary

"The Minister of Health said that by 2013 all hospitals need to be accredited or else they will be shut down"

(Lecture on Ethics at Al Kasr Al Ainy, 2010)

"The Maristan School which was originally opened for teaching cadets medicine prior to admission to the school at Abou Zaabal, is now no longer needed. It is not possible to obtain the services of competent teachers from Europe to teach in this school with view of improving its standards, which I consider very low. Those of its students who can read and write in Arabic correctly will be sent to the medical school at Abou Zaabal..... As to the Maristan School, I propose to close it"

(Clot Bey in Mahfouz, p.33-p.44)

This research is not suggesting that public hospitals should not be criticized for their ill-equipment, but what should be highlighted here is that the solutions offered by the Ministry of Health do not tackle the economic structures that lead them to be so but simply seeks to apply ethical regulations that are not feasible. Therefore, when the professor in the lecture on ethics explained that hospitals that are not certified according to these criteria of good medical practice, discussed above, will be shut down, it ultimately means that public hospitals are those that are more susceptible to shutting down. Consequently, the poor will be left with no health care at all rather than the compromised one they are provided with now. Note that for example the concept of justice, discussed in the above chapter, will not redeem the poor's inability to

access medical care as unjust since it does not at all consider those that are completely out of the doctor-patient interaction. Justice or injustice is only present when the interaction is already taking place. Thus, the unavailability of the interaction is not considered as part of medical ethics.

Newly rising discourses have been attacking the ill-equipment of the public sector and there have been several proposals of privatizing it rather than improving it. While the Ministry of Health's struggle for privatization has been a relatively difficult one, met with opposition, applying "good quality" standards as a condition for not shutting down will be an easier way to eventually get rid of public health services. When the minister of health declares that any hospital that does not have accreditation will be shut down and make the conditions for accreditation unfeasible for the public sector, it ultimately means that the public sector will be discarded.

It is not the first time that "new" international standards, or more accurately Western standards, of health have been used as means of getting rid of an undesired existing system. Under Mohamed Ali rule and with the management of Clot Bey, Maristans (Arab hospitals) were shut down when they could not meet Western standards of health services and were left first to deteriorate so as to be replaced. Similar mechanisms are being observed today. International standards, accreditation and ISOs are the key words for attacking what is now presented as the "old system". In the name of better quality health care, provided by international standards and accreditation, the poor are being pushed out of the system of health care all together. The public sector, with extremely low funding, will not be able to meet such standards and will ultimately not be accredited. In the name of ethics and good quality health care, public hospitals will be

shut down and the private will be all that is available. Individual patients, rather than the state, will become responsible for providing themselves with health services, like most already do. By the same standards of medical ethics and quality, the ethical responsibility of medical care is shifted to become that of individual doctors just as it shifts the responsibility of being provided with health care is shifted to individual patients. The state will no longer have a role in medical care all together but only individual subjects will.

The new discourses on health and the changes it proposed with them are not at all limited to a couple of courses on ethics and patient-doctor interaction applied as part of the medical education plan. On the contrary, the Ministry of Health has been for several years now discussing a complete plan regarding changes which need to be applied to the health sector. These changes may include bettering doctor-patient interaction through enhancement of educational courses but is not at all limited to it. For several years now, the Ministry of Health has been highlighting the failure of state led medical institutions. The critique of the public health sector has started with a USAID study that was launched in 1997 to assess the quality of the public health sector, called “The Data for Decision Making” project⁸. The study followed discussions over restructuring and reforming the health care under what was termed the Cost Recovery Program for Health which eventually led in 1988 to a pilot project upon which all following proposals were made. The pilot project, which was also USAID approved, involved developing and testing cost recovery systems in pilot HIO (Health Insurance Organization) hospitals, improving efficiency and management of the HIO and the CCO (Curative Care Organizations) and expanding private sector financing. In other words, the pilot project was proposing that the inefficiency and mismanagement of the current HIOs and CCOs were due to it being free of charge and state led

⁸ www.healthsystems2020.org/files/1340_file_te5v7fin.pdf

as opposed to market led. Therefore, the pilot project was applied to show that a privately financed for fee service would be more efficient and better managed.

Based upon this argument all else followed including the public health sector study that was launched as part of the “Data for Decision Making” project and that aimed to reveal the failure of the public health sector. Disregarding what is happening in the private health sector, the Ministry of Health with the backup of the USAID, has worked on revealing the failure of the public health sector alone to argue that if it is privatized, efficiency and better management will be accomplished. Efficiency and better management also became the two key words to assess quality of health, disregarding all other factors. Ultimately, the proposed changes were finally articulated as follows;

- freezing the construction of new Ministry of Health Hospitals (MOHH) (i.e. free-of-charge public hospitals)
- Transferring the existing MOHH to other organizations (i.e. the private sector)
- Changing the operation of the MOHH to be under cost recovery (i.e. services are in return for a fee)
- Opening up the MOHH for use by private practitioners
- Transforming the MOHH to be autonomous (i.e. have the freedom in determining internal regulations including employment)
- Creating bonuses and incentives for MOHH employees
- Improving CCO's (Curative Care Organization) autonomy
- Unifying existing social health insurance laws
- Freezing the expansion of HIO (Health Insurance Organization) benefits to other groups

- freezing the construction of new Health Insurance and Hospital Clinics (HIHC)
- Sale and transfer of HIHC (i.e. to the private sector)
- Establishment of a National Health Insurance Fund
- Abolishing Guaranteed Government Employment
- Enabling MOH (Ministry of Health) to transfer and reduce its own personnel

In addition, the draft law in point 3 Article 6 stipulated that fees are to be paid upon receiving different services including hospital fees, General Practitioner fees, specialist fees and home visit fees. These fees will be decided upon a decree from the Ministry of Health not exceeding 25% of hospital costs and 1/3 of drugs and investigation outside hospitals. Moreover, the WB's (World Bank) "Proposed Amendment of the Development Credit Agreement" proposed for a pilot project the establishment of a "Family Health Fund". This WB pilot project would then act as a precursor for a National Health Insurance System, mentioned above, for a basic minimum universal package of health services. In other words, all people will be insured by a minimum package that only covers basic primary health care. This fund will be covered not by government alone but by premiums and donations.

In short, the plan is to gradually move what is now in the hands of the state to be managed and run by the private sector. To guarantee efficiency and quality, two components lacking in the public sector according to the USAID study, the private sector should take over. However, there have been no studies done about the private health sector and no clear plan was provided as to what will happen to those who cannot afford private hospitalization that exceeds the primary health services covered by the proposed universal package of health. The discourse tends to idealize the private sector and condemns the public as a necessary failure.

Furthermore, the Ministry of Health has proposed that different insurance packages are made available to cater for different health seekers. In other words, the new insurance law proposes the formal hierarchization of patients. While currently, those who seek public health care may get a lower quality health service than those who seek private and those who seek cheap private health institutions get a lower quality service than those who seek more expensive private health institutions, now the state is proposing that within the same institution different categories of patients can exist. However, the hierarchization should not differ in quality, quality will be standardized through quality control international accreditations, but through the level of care patients receive. In other words, the more the patient pays the more services s/he gets. Those that only pay for the compulsory primary package only receive primary health care and those who pay for higher coverage packages receive services for secondary and tertiary health services. Therefore, as Dunn also argues about international standards applied in Poland, such gradations forced to standardize services do not only represent “differences in wealth”, as the current system now does, but it also represents 'difference in worth” (Dunn 2005, 183). Although the current health system discriminates patients according to wealth, it still holds the rational that supposedly all should receive full health care. However, the newly proposed standards of health imply that those who can afford the higher cost insurance packages are worth more than those who cannot in terms of the health care they deserve to get. Consequently, concepts of Rights also changes with the new proposals.

Moreover, the idealized private sector, according to the ‘new’ discourse, provides quality and efficiency. No reference of over-medicalization, quickly mentioned during the ethics lecture, is ever discussed. Although private practice does not lack scandals regarding the quality of its health services, none of that is discussed in state discourses as a structural problem. For

example, in the lecture on ethics, the professor explains that the doctor has the right to reject a treatment to a patient if he/she finds it unnecessary and then jokingly says “if you [a doctor] think an operation is unnecessary, for example, you have the right not to do it...do not worry the patient will find many others who would agree to conduct an unnecessary operation”. The professor's joke implies that many doctors would gladly take over an unnecessary operation just to get paid more. However, in official state discourses such practices of over-medicalization, that are so common that they have obviously become part of the physicians' daily black humor, are not treated as structural problems that rise as a result of profit-led medicine, but only as unique incidences of individual unethical medical behavior that maybe controlled by implementing some courses of medical ethics within universities and regulated through international standards and supervision.

Ignoring structural barriers to ethical medical conduct that appear as a result of profit led medical care, especially in a developing country such as Egypt where informal sectors and black markets are an integral part of society's makeup, may prove on the long run very problematic. It is very likely that small private hospitals, clinics and labs that would not have a competitive advantage if they adopt international standards, would resort to the bribery of inspectors or the mobilization of personal relations to evade regulations. Such practices of corruption are common and have contributed to the failure of the old socialist oriented system of governance that the state now condemns as the source of corruption. For example, it is well known that public health services that are supposedly for free are used by medical doctors to generate profit by illegally asking patients for money. The argument put forward by the Ministry of Health holds that if patients pay anyways through corruption, they can pay the same through legal channels and are at least guaranteed better health service that are monitored through international regulations.

However, in this discourse the new black markets that will be probably created in the light of the new system are overlooked and focus is only given to the current black markets created as a result of the failing state led public sector. By ignoring the socio-economic structures of the market, and that lead to this corruption, the discourse is able to blame the source of corruption solely on the 'old' public service sector.

Moreover, the argument propagated by the Ministry of Health also quickly tackles under-medicalization of the poor who cannot afford to pay in return for medical care, by ensuring that the "poor" will be state covered. However, the "poor" are loosely defined and the amounts that the "non-poor" are expected to pay are never articulated but only percentages of unknown numbers are. For example, the proposed changes postulate that a patient is expected to pay no more than 25% of hospitalization fees, which could range between any two numbers. When I asked interns whether they thought that paying for health care would be a solution to the overburdened hospital they are working in, many explained that health care is simply too expensive. In a focus group interview which included 4 interns; 2 women and 2 men, one woman explained and all seemed to agree that:

"The prices of health equipment are just un-affordable...and do you see how the patients brought in here look like [read: poor]? If we would only calculate the costs of the equipment used it will go up to thousands that is without even including doctors' fees"

The "thousands" used by the intern was basically implying that one does not need to be the poorest of the poor so as not to be able to afford health services beyond primary health care. However, what the Ministry proposals seem to imply is that only a certain small segment will not be able to afford health services and these will get special treatment. However, what seems to be implied by several interns is that this segment that cannot afford health services, beyond

primary care, is a big one not only because a lot of people are very poor but because health equipment alone, disregarding the doctors' fees, is simply too expensive even for those who are not considered extremely poor. In such statements from interns, it can also be observed that the neo-liberal discourse which seeks to move all services to the market and leave the poor for NGOs or charity is not fully hegemonic either. While most interns would not necessarily choose to work in public hospitals, many of them express the need for the public health service to exist to serve the poor. Still, they would rather serve the poor in NGO settings, for their better conditions. In other words, interns frequently defend the right of the poor to access health care but are rarely willing to compromise their careers for it. For those who give the situation a bit more thought when planning their future options, they prefer serving the poor in NGOs, whether religious or secular. While some might not defend the neo-liberal discourse in theory, they do in practice.

To sum up, proposals presented by the Ministry of Health, disregards the weaknesses of a market-led health sector and highlights those of the public sector to create an idealized image of the private cost recovery system which it intends to apply. By doing so, it does not only defend the expansion of the private sector but it also defends the complete abandonment of the public, under the name of efficiency and quality. In the lecture on ethics the professor announced that accreditation, which follows the international standards of health that includes the ethical guidelines taught, will have to be adopted in all hospitals. She also added that the Minister of Health announced that those hospitals that are not accredited will be shut down. With all the investment going into the private sector while the public sector investment is constantly being cut down, the public sector has no chance of being accredited simply because, as shown above, with such low funding such standards cannot be met. Consequently, the public sector, in the name of "good quality", will be completely abandoned and health services will be left to the

market. However, the market will have to abide with the international standards of health and gain accreditation. Still such accreditation does not consider who has access to health and who does not and what loyalties doctors have to patients when they are mainly guided by profit. In other words, international standards of ethics are shaped to apply to the market-led health model, definitions are molded to serve it, and the public is left to deteriorate so that it does not meet these standards or any other for that matter.

This imagined also involves a lot of individual responsibilities. Since social and economic structures are often marginalized in the debate, individual actions are at the core. Neo-liberal subjects that are “free” to choose how to act and shape their lives are being created (Ali 1997). As observed in the new courses, interns are made to believe that “ethical medical conduct” is in their hands. The whole discourse roams around this idea, which basically argues that individual contributions and actions will lead to the desired health care.

The private sector is provided as the solution for a better health care service. Since all its shortcomings are ignored and an ideal version of it is imagined, the proposed changes seem to be providing the imaginary that was promised by the new lectures, courses, IOs (International Organizations), NGOs and the media. The hospital of 'Lahazat Harega' will supposedly be provided by the proposed changes and even the poor discussed by the Ministry of Health seem to resemble those in the soap opera, they are the type of poor who can still afford what even to many “non-poor” Egyptians is unaffordable. In short, the Ministry of Health’s proposal provides the imagined which has been in the making for the past almost 20 years.

Conclusion

Just as modern medicine forced itself in opposition to any other form of healing that existed in Egypt before the 1800s (Chiffolleau 2005; Shukrallah; Mahfouz 1935) to create a new mode of governance and control, neo-liberal policies and economic structures are also forcing themselves as the only “correct” set-up for health services, creating again a new mode of governance. Again in the name of scientific and objective knowledge a new mode of governing is being created, this time presenting itself in the form of international standards and accreditation criteria. However, this time the rationale by which the discourse is operating had its roots in already existing institutions (Shukrallah n.d.). In other words, the basic concepts of neo-liberalism were already embedded in the existing medical institution and culture, facilitating its domination.

Through analyzing the courses on ethics in relation to the practices of interns, this study aimed at revealing how acceptance to the gradually dominating neo-liberal rationale is being created. Interns are constantly negotiating with neo-liberal theories on medical care, comparing it to what they experience in their daily practice, and try and make sense of the contradictions they witness between the discourses and their daily realities. Despite the apparent contradiction which they often articulate clearly, state “corruption” seems to over shadow any other reason for this gap between theory and practice. Ultimately, interns adopt some aspects of the neo-liberal rhetoric, despite the obvious contradictions, and to an extent start believing that the imaginary it produces is possible if only “corruption” is abolished.

As Rose argues, neo-liberalism is not a political rationality that governs through command or control but one that operates through the calculative choice of formally “free” actors. Hence, the low faith expressed in state institutions and agents and the interns' continuous critique of them is irrelevant to how influential the neo-liberalist discourse has become. Although propagated at times through some state institutions and agents that may enjoy little hegemony, the discourse is increasingly adopted by individual interns in their daily and future choices. Market rules are adopted as the base on which all social conduct should be built and emphasis is put on individuality rather than social solidarity in most of the interns' choices and daily practices.

Although interns perceive the gap between the “new” discourse on medical practice and their daily practice, their critique is not directed towards the discourse that emphasizes the role of the individual rather than the social and economic structures, but towards corrupt individuals within state institution. They often blame corrupt state agents, whom they describe as mis-distributing the hospital's budget causing the shortage of equipment witnessed at the hospital. In short, interns defend neo-liberal discourses, when they individualize the failure of the health care system, claiming both that those interns who want to learn can if they make the best out of their experience in their internship year and, that officials can teach interns to practice ethical medical care if they really intend to.

Moreover, alternatives to state institutions, such as NGOs and religious institutions, also adopt the same neo-liberal discourses, contributing to their gradual domination. Even though religious and “developmental” discourses emphasize social solidarity values through charity and altruism they highlight the role of individuals and their choice within market rules to satisfy such values, rather than provide a system of social solidarity. In other words, individuals are expected to

freely choose to help others when their role in the market allows them the time and the capacity to do so. At the end, the market dictates how much social solidarity will possibly succeed.

Acceptance of the neo-liberal discourse paves the way for the state to take a further step in withdrawing from its role as service provider and prioritize market-led medical care. Although this study is not claiming that these couple of courses, implemented at Al Kasr Al Ainy, are the reason the neo-liberal discourse is starting to dominate the health sector. It only reflects how, through civil society institutions such as the health education institution, a discourse which individualizes state responsibilities is created. By such courses and others, media channels, health campaigns, and NGOs, state responsibilities are passed on to individuals, facilitating the proposed policy changes. In other words, such discourses are creating individuals who would accept policies of privatization before they are even implemented or proposed. Furthermore, the lack of trust in state institutions, of which some are propagating the neo-liberal rationale, does not decrease the legitimacy of the discourse, on the contrary it strengthens it. The lack of faith in the state is only used to argue that since state institutions cannot be trusted, the private sector will manage services better. Consequently, loss of faith in state institution has ironically created hegemony towards its proposed policies.

Consequently, the Ministry of Health could use the lack of faith in state service institution to propose its new policies, namely the privatization of the HIOs. However, although this research shows here that the neo-liberal rationale that is starting to dominate the health profession and institutions may facilitate the acceptance of the newly proposed policies the new proposals were met with many objections and were not passed on. While some medical professionals fought

against the privatization policies⁹, showing that the neo-liberal rationale is still being resisted within the medical institution, the main barrier to the policy implementation were the poor who used the services and whose needs were completely marginalized by the new discourse. Although the discourse may be gaining acceptance within the health profession and institution, it is harder for it to gain acceptance within the group that is being most marginalized by its rationale. However, I argue that a study that examines whether the neo-liberal discourse is also being individualized by the poor through NGOs, religious institutions, the private sector and other state institutions than those of health and medical education, is required.

⁹ <http://www.ahedegypt.org/>

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