1999

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Between Field and Text: Emerging Voices in Egyptian Social Science

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CAIRO PAPERS IN SOCIAL SCIENCE
Volume 22, Number 2

ON MEDICAL ANTHROPOLOGY, RESEARCH, AND RESEARCH PRIORITIES: NOTES FROM CAIRO

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Introduction: From the Viewpoint of a Medical Anthropologist

This paper is based on fieldwork for my Ph.D. dissertation in medical anthropology[1]. The study explores dynamics of continuity and change of contemporary health practices in Cairo and emphasizes how low-income families perceive the body in times of illness. I put these in the context of larger discourses on the body and health presented in newspapers and health pamphlets authored by physicians, herbalists, and faith healers. As a medical anthropologist I view health and illness as influenced by psychological, social, economic, and political conditions, not merely the 'objective' result of physical conditions. Unlike biomedical and public health studies, or sociological studies of medicine, medical anthropology seeks to understand how different health resources available in a society are conceptually and materially reproduced. It is concerned with different modes of therapy as ways of realizing social healing and thus contributing to the maintenance of social order.

Furthermore, medical anthropology seeks to understand the different ways these conditions shape and are shaped by knowledge, including knowledge produced by medical anthropologists. In the words of one prominent medical anthropologist, medical anthropology involves a constant search for a more satisfactory epistemology (Young 1982). Two decades ago medical anthropologists focused their studies on what was then called ethnomedicine. The term referred to those therapeutic systems that belonged to

[1] My research in Egypt was funded by a Karim Rida Said Scholarship of the Cambridge Overseas Trust, University of Cambridge, England, and a MEAwards grant from The Population Council, Cairo. I am further grateful for the support provided through a research fellowship in the Anthropology Department at the American University in Cairo. Special thanks go to Petra Kuppinger for her support, inspiration, and thoughtful comments.

particular ethnic groups and that were based on assumptions and techniques that were essentially different from modern biomedicine. More recently those studies have been criticized for their cultural bias toward modern biomedicine and for employing double standards when evaluating treatment effects (Lewis 1993). Lewis writes: "Double standards go unrecognized in our actions" (ibid.: 192). In the case of biomedicine, therapeutic effects are taken for granted and go unquestioned. There are many examples of biomedical therapies in which we once believed and hardly questioned. Conversely, speaking about those who try to understand how non-Western therapies work, Lewis notes:

> We are ready .... to credit the mysterious powers of psychological and psychosomatic forces when the cases come from distant places and are about Aborigines or Africans. The readiness goes with a certain romanticism about 'exotic' peoples and a set of attitudes or beliefs attributing emotional lability or oddness to other people, especially those called primitive, simple, or oriental (ibid.: 193).

In the last two decades modern biomedicine and biology, especially with their underlying social assumptions, have become central subjects for anthropological investigation. Emily Martin's book on the concept of the immune system is an excellent example of one such study. The author observes that products of science move out of laboratories to wider society. Whether these products continue to exist, as well as they ways in which they exist, is by and large dependent upon social and political factors. Modern medicine contributes to social control through extending regulatory conditions of the laboratory to the outside world (Martin 1994).

Similarly, in this paper I define science, including medicines, as a particular kind of social knowledge produced within identifiable institutions and conditioned by social, economic, and political interests. In other words, scientific knowledge is produced in regulated, professional environments. It acquires new meanings when disseminated and utilized by other social groups depending on their respective social and cultural circumstances. This interchange between expert and community knowledge takes place between people living in different social and cultural conditions and motivated by various political interests.

The Significance of *'Iddagt*/Pressure

This paper will focus on one theme from my project, the prevalence of *'iddagt* (literally: pressure), a common malady in Egypt. *'Iddagt* refers to the clinically-defined condition of hypertension or high blood pressure, but also includes a set of complex social and medical problems with implications far beyond physical discomfort. Indeed, *'iddagt* is a household term in Egypt that refers to a whole set of adverse life conditions collectively called *dughut 'il-hayah* (pressures of life, *dughut* is the plural of *'iddagt*). Physical discomfort resulting from elevated blood pressure is only one manifestation of those pressures.

In the initial phases of my research I noticed that despite its wide prevalence in Egypt, *'iddagt* has received almost no attention in social studies of health. The only recent study available is a survey focusing on the concept of hypertension, which states that it is a widespread medical condition among Egyptian men and women. This study elaborates on the physical details of the disease as defined by the medical literature but does not make reference to cultural understandings of hypertension as represented within the concept of *'iddagt* (Ibrahim et al. 1995).

The theme of *'iddagt*, which was not initially a theme of my research, emerged as a central feature of it after it was repeatedly mentioned in conversations as an important problem. Neither physicians nor patients are certain of the causes of the disease, which remains a subject of debate. Physicians refer to inexplicable cases by the label "essential hypertension" and use the term specifically in English. This term is used when the condition of abnormal blood pressure cannot be ascribed to one or a set of specific physical malfunctions. In treating the physical and the social discomforts of the condition, patients as well as physicians experiment with different therapies until one works. A prominent physician used the analogy of dressmaking to describe this process of experimentation. He said: "physicians in hypertension are like tailors; they sew up specific treatments for specific individuals." He meant that physicians always combine different kinds of therapeutic measures in their prescriptions for treatment. Each specific combination is good for specific group of individuals characterized by specific constellations of symptoms. According this physician, the processes of prescribing therapies are highly speculative. Meanwhile, patients ascribe

the illness to a set of different causes including, but not necessarily limited to, those mentioned to them by physicians. Likewise, their treatments are based on their experiences, which include, but often go beyond, physicians' advice. The contrast between physicians' explanations and those of patients' is not an absolute one. First, there are physicians who are ill with hypertension, as discussed below. Second, an abstract and complete definition of hypertension or *'iddagt* does not exist in any single individual's experience, whether that individual is a physician or a patient. The difference between them is organized around particular ways of embodiment. That is, each case has its own unique ways of embodying available interpretations. These interpretations are products of a variety of social, economic, and cultural contexts. In this paper I am concerned with aspects of hypertension that are controversial and thus constitute a theme appropriate for the discussion of research priorities. Empirical interpretations of *'iddagt* overlap in complex ways and thus require separate analysis.

Given this uncertainty surrounding the causes of hypertension, I set out to investigate the social and cultural factors that reproduce varying patterns of interpretation of the disease and its treatment. My aim is not to show how consistent and true certain interpretations of hypertension are. My purpose it to identify the process through which certain interpretations become more powerful than others. In the process of reflecting on hypertension and *'iddagt* and discussing my thoughts with my interviewees and research assistants, a parallel set of questions emerged. Was *'iddagt* a vital topic for research? Should its study be of priority? What were the best methods to study it? Some of those suffering from *'iddagt* questioned the need for research. They argued that *'iddagt* is but another expression of *dughut 'il-hayah* (life pressures), which were obvious and did not require further scrutiny. Physicians, while recognizing the significance of my research, tended to argue that my methods were not 'scientific' enough. They urged me to base my research on larger samples of people who tested positive for high blood pressure.

Finally, aspects of my identity must have influenced the questions I raise in this paper, and in my research as a whole. My identity must have influenced the reactions of the interlocutors in the following debates. Perhaps an advantage to investigating issues of medical anthropology in Egypt was my position as a male Muslim Jordanian. As such I was perceived as an

insider in many respects, as people identified me as a person from a country experiencing social, political, and economic problems similar to their own. At some moments, however, my nationality positioned me outside a nationalist Egyptian discourse. Nevertheless, the families I visited treated me in a friendly manner and willingly participated in my research. In the beginning they supported me as a person pursuing a university degree, an endeavor widely respected among all family members. After an initial phase of my research too, a friendly relationship developed between me and several family members. The strongest relationships I had were with males and females of my age group. In contrast, senior physicians in the health bureaucracy were less interested in meeting me, an Arab student researcher who was not looking at health issues from a perspective of 'hard science.' They often put on a patronizing tone and attitude while discussing their views with me.

Below are some examples of reactions to my research that illustrate different perceptions of health and health research.

What to Study?

> *"Mohammed, why don't you work on depression? Why hypertension? Depression is much more important to study with people like us!"*

Dr. Khalil, a prominent physician and director of a major public hospital in Cairo, addressed me with these words when I was in the process of choosing hypertension as a central focus for my project. The physician's suggestion opened up an opportunity for discussing several issues crucial to hypertension and "hypertensives," as Dr. Khalil and many of his colleagues refer to patients suffering from *'iddagt*.

In many of the narratives that I had collected about *'iddag*, individuals referred to feelings of frustration, disappointment, and anger, using the collective term of *'il-zaʿal*. Men and women explained that their high blood pressure derived in one way or another from such emotional states, which they put in the immediate context of social factors such as severe environmental pollution, lack of space in an extremely densely populated city, and ever-rising prices even for basic needs. Everybody engaged in

medical research or work with hypertension in Egypt is familiar with the explanatory role that *'il-zaʿal* takes in many or even most patients' narratives. The crucial role of this concept was taken for granted in conversations between Dr. Khalil and myself. Consequently, in our conversations outside of his office, in the hospital outpatient clinic or the hospital gardens, Dr. Khalil frequently noted: "the disease as such is not the major problem in people's lives; it is rather the suffocating conditions under which they are forced to live." In his own way he appeared to acknowledge and, to a certain extent, agree with the reasoning of his patients. Why then did he suggest that I focus on depression rather than hypertension? Could depression be equal to *'il-zaʿal* in his thinking? Why then did he not use *'il-zaʿal* rather then depression? Was it because he felt the concept of depression could better represent his patients' feelings?

I was surprised when Dr. Khalil once called me to his office with the words:

> *I have time now, you can make an interview with me, and I will tell you everything about hypertension. It is a very common disease and you need to know the correct facts. We physicians even predict what will happen to the patients, not only what has happened to them.*

Dr. Khalil proceeded to give a lengthy explanation about what is generally known and written about hypertension in medical textbooks. In his small lecture he was keen to use English in order to emphasize aspects of his discourse. He explained that blood pressure associated with high salt intake, kidney problems, diabetes, and other physical conditions. In this context hypertension was associated with civilized lifestyles and thought to be common in large cities. He went on to cite a number of recent studies that focused on the more complex details of the disease. The research papers to which he referred addressed purely chemical and biological aspects of the illness. They had been conducted in Europe and the United States, which seemed far away from my research concerns about hypertension in Cairo. As a response to my repeated questions about his assessment of the possible causes of hypertension in the particular case of Egypt, he listed a number of practices and characteristics that he regularly observed in his patients and that he believed contributed to increased blood pressure. These included increased

tension and poor eating habits (for example, consuming overly salty or spicy foods), but also the experience of stressful life conditions.

I realized the significance of Dr. Khalil's views when I wondered why he chose to use English in speaking to me instead of Arabic, and why he preferred depression to *'iddagt* and its associated emotional conditions (*'il-zaʿal*)? Of course English is one of his signs for profession and class. More significant is the possibility that he felt he had to translate his patients' feelings into concepts that he best understands as a physician. But depression only partly translates to the concept of *'il-zaʿal*. It falls short of the specific cultural and social meanings that the latter term includes. Furthermore, depression has not been deconstructed to explore its specific cultural form and relevance in Egypt. The result is a gap between professional knowledge informed by studies conducted elsewhere and an everyday practical knowledge inspired by a specific cultural context.

The contrast between his views expressed in informal encounters and his more official medical discourse points to underlying shifting positions for conceptualizing health problems. Each position entails a different set of notions and actions. In our garden encounters he mentioned ideas related to issues and perceptions of everyday life. In his office he delivered what could be called his 'professional' vision, which derived from his official position. The latter reflects the larger biomedical discourse. This discourse tends to lead to a specific set of actions and is shared by other physicians. Dr. Khalil was keenly aware of the priorities that such an approach favored. He readily suggested that a solution to counter or control the widespread existence of hypertension was to tighten the rules of physical examinations and make blood pressure tests routine in all clinics in the country. Readings resulting from such large scale testing would constitute an essential advance in studying hypertension in Egypt and subsequently help to better understand and control it.

Dr. Bassam, a colleague of Dr. Khalil, suffers from elevated blood pressure; Dr. Khalil kept jokingly suggesting to me to take Dr. Bassam as a typical case. Dr. Khalil's reasoning why his colleague was such a typical hypertension case was rooted in his practical and everyday vision of the disease when he remarked: "Dr. Bassam suffers from a stressful job where he has to work very long hours. He has been married twice which put a heavy financial burden on him."

Despite this more practical and everyday reasoning, Dr. Khalil and Dr. Bassam also debated, in relaxed encounters, the various aspects and possible physical complications of high blood pressure as much as the latest means to overcome them. Dr. Bassam revealed his trust in Western biomedicine and its products when he noted he brought all his personal medicines from abroad because locally available therapies had too many hazardous side-effects. Some of the latter, he noted, were harder to control than hypertension itself. Needless to say, his personal choice is not just an issue of belief in medical systems but also an economic and political issue within the larger sphere of the global politics of pharmaceutical industries.

With regard to their patients' everyday experiences, yet another set of very concrete problems arises: severe economic and social constraints that limit access to existing health services and necessary medication. It goes without saying that access to physicians' biomedical treatments is invariably linked to the larger context of the economics of health. Treatments and solutions, in an almost vicious circle, reproduce aspects of the problems they were supposed to solve. The remarks of a middle-aged patient of hypertension poignantly illustrate these circumstances: "These pills [...], even the idea that I have to buy them at such high prices raises my blood pressure." This remark points to the sharp contradiction between physicians' high-cost technological solutions and people's life conditions.

Is This Science?

> *This is philosophy, or at best a good exercise in prose writing; it is definitely not a scientific project.*

These words were the reaction of Dr. Mustafa to the idea of my studying high blood pressure from an anthropological perspective. Dr. Mustafa was reacting to a brief written description about my project. Expecting a research outline consisting of numbers, figures, statistics, sample surveys, or chemical analysis, Dr. Mustafa perceived a qualitative study using methods such as participant observation and informal interviewing as unscientific.

Dr. Mustafa is the head of an important medical organization whose central concern is the improvement of general health conditions in Egypt. He also occupies a high position in the Egyptian health bureaucracy and

consequently commands considerable influence within the medical research field. Proper scientific research, he argues, is based on statistical surveys and uses properly controlled numbers of biophysical and chemical variables in a standardized manner. In other words, research that falls in the category of what he defines as the arts and humanities is hardly scientific. The latter, by such logic, have little in common with Dr. Mustafa's idea of proper science, and hence have little explanatory value for medical questions. Dr. Mustafa's statements raise broader issues regarding questions of the representation of health and disease. He, of course, suggested only one possibility, a biostatistical one, squarely located within the biomedical model. He finds nothing to be gained from what he sees as a vague and 'artsy' qualitative social science method.

Dr. Mustafa's views best represent a method favored by other physicians and patients. This method involves strong adherence to a supposedly value-free scientific medicine that rests upon empirical analysis. His suggestions to me of how to study hypertension were strictly about methods. He did not question the significance of the topic of hypertension, which he recognizes as a vital subject for research.

It was obvious in this and other meetings that the relevance of my research, which rests upon phenomenological understanding of human practice, is not particularly clear to Dr. Mustafa. As such it is not of particular interest or relevance to the scientific approach that his views best represent.

In my conversations with Dr. Mustafa and his colleagues, I emphasized the relevance of perspectives that transcend pure medical approaches to understanding health and illness. One of the physicians recognized my emphasis as relevant and essential to medical research. This doctor was among the very few physicians I met who had studied public health after his first degree in medical practice. Another physician is a cardiologist who could have been immensely interested in my research had it included larger numbers of patients. A third physician is a cardiologist who was equally interested but could not offer help because she did not have permission from Dr. Mustafa, her boss at work. The medical profession in Egypt is hierarchically organized with most of the power resting in hands of famous and established male physicians. Furthermore, the political power of the medical profession in Egypt is much greater than the power of social sciences. I believe that as

long as alternative approaches, including the ones I suggested to the physicians, do not have institutional support, the emphasis on social and economic aspects of health care will not take place.

Who Ever Reads Research?

> *Honestly Mohammed, I cannot see who will ever be interested in what you are collecting from people. I am afraid your dissertation will end up collecting dust on some library shelf like any other piece of research in this country.*

Dr. Samir, a friend and collaborator in my project, made this remark to me in a discussion about the frustrations of research. Dr. Samir is a general medical practitioner but at present is unemployed. In the past he worked for government and non-governmental organizations. Two years ago he quit his job at a dispensary run by a charitable Islamic organization that served the large population of a low-income neighborhood. Dr. Samir noted that he observed that people's health and economic needs went far beyond the pure medical services available. In a bitter tone he recalled his constant frustrations with daily confrontations with human suffering and complaints while realizing that he had extremely limited power to help. Subsequently, Dr. Samir joined a program of graduate studies in anthropology, hoping this change would help broaden his perspective and understanding of the social and economic dimensions of health care. Nevertheless, Dr. Samir is not entirely convinced that research can really engender the changes for which he had initially hoped. He is mainly concerned about everyday realities and circumstances and is set upon studying poverty as a main factor responsible for disease and poor health. Recently he was hired by a non-governmental research center to participate in a study about the culture of poverty. He accepted the job because he felt the results of the project could ultimately feed into income-generating projects that the center planned to initiate.

Realizing that we had a lot of similar concerns about research, Dr. Samir and I spent long hours discussing these issues. Dr. Samir was to a certain extent intrigued by my ideas that studying individuals' perceptions of their health conditions was essential to realizing a long-term and in-depth understanding of the broader landscape of contemporary health concerns and systems. However, he believed that writing about patients' views would be of

no major importance because people in power would not take it seriously. Dr. Samir, with his experiences as a medical student, political activist, and keen observer of everyday life, constituted a productive challenge to me; we learned from each other's perspectives. He felt that there was hardly any connection between the various programs provided by the government and other agencies, the resulting research papers and dissertations on library shelves, and an actual social reality. Criticizing the government and other health projects, he insisted that most of those programs were improvised activities based on visions and agendas of those in charge, or worse still, projects conceived in accordance with the immediate political needs and goals of the respective institutions. Dr. Samir is positive about the idea of research. All he is opposed to are research topics which do address questions relevant to his own, namely, ones related to economic poverty. He is also critical of the way the government positions research and researchers.

What Are the Real Priorities?

What do you mean by research priorities? Do people have anything to eat in the first place?

This was the first response of Salwa, who worked as my research assistant, as I was contemplating ideas for the present paper. Salwa is a student and political activist and is also involved in a number of organizations that work on environmental and health issues. Abstract research priorities meant little to Salwa when many of people's basic needs and rights are not guaranteed.

She has been involved in a number of social and medical research projects and therefore has clear ideas about social science research in Egypt. She insisted that the problem as far as research priorities are concerned relates for the most part to the availability and types of material support for research projects. Her familiarity with the research scenery allowed Salwa to draw up a list of topics such as human rights, environmental themes, women studies, and population studies as currently being the most feasible, fashionable, and fundable. It is not that Salwa was opposed to these topics as such; she did see them as vital and significant. However, she insisted that there were many more, and possibly more crucial topics that were of urgent relevance in

contemporary Egypt. She noted that, for instance, basic needs such as food security and health care should be given priority. In response to my question about how she thought some topics had become so fashionable and consequently fundable, Salwa remarked that she thought there were a number of Egyptian researchers who knew which topics to market and in what manner with international funding organizations.

Salwa's remarks illustrate an attitude that I frequently encountered. Her main question is why people's basic needs, such as their economic needs and rights, should not be considered as priorities for research? Interestingly enough my research interested Salwa as it touched upon people's difficult economic conditions, which she considered an indirect cause for ill health.

Research! So what?

So, Mohammed, are we going to benefit from your research? Perhaps you should give us one little piece from your doctorate!

In one of those curious moments when joking friends and bitter social realities coincide, Um Ahmed, a 60 year old woman whose family I visited frequently throughout my research, made this remark to me. I had come to know Um Ahmed, her husband, and their large family through their son-in-law, and soon took to visiting them regularly. It turned out that both Um and Abu Ahmed suffered from high blood pressure. My close relationship with the family allowed me to better understand everyday details of living and coping with the illness within the social, emotional, and economic context of this household. Remarks like the above, cynical yet friendly, occasionally made by Um Ahmed, were harsh reminders of the problematic nature of every anthropological research effort. Um Ahmed hit me at the core of some of my theoretical and ethical insecurities. What really was the use of my study for those who helped me and opened their doors, hearts, and minds to me? Was that study in any way going to influence their lives? How and where is my study going to end up? Will it be accessible or beneficial to people like Um Ahmed? Does Um Ahmed regard my research as a priority? Such questions will never have immediate answers given the existing power differences between researchers and research participants. I would like to emphasize that considering such differences should be part of our search for research

priorities.

Conclusion

My larger project aimed at illustrating different ideas and visions about the human body and how these ideas have different powers. Similarly, if society is seen as a social body, analogous to the human body, then the way in which research priorities are conceived is subjected to the negotiation of power relations. Social perceptions vary, for instance, for different classes, professions, and genders. The interlocutors in this paper are not in agreement with my or each others' ideas of research or research priorities. I presented their views in order to emphasize these contrasts and to argue that the differences between them are reproduced by the power structures in which they live.

The views about research priorities are based on knowledges about a multiple and dependent reality. Depending on this knowledge certain problems are represented as more real than others and their study more significant. Dr. Mustafa, for example insists on seeing such reality through numbers and facts produced by physical examinations. His methods in examining medical conditions are required and backed by his powerful position, which seeks priorities conducive to its maintenance.

But ways of representation vary even within the mind of the same subject. Physicians such as Dr. Khalil and Dr. Bassam who present conflicting ideas about the causes of hypertension also have shifting positions with regard to research priorities. Their views delivered in informal settings sound close to their patients' thoughts and feelings. But when asked further about these feelings, they immediately translate them into their biomedical counterparts.

When Dr. Bassam and Dr. Khalil are personally concerned with hypertension/*'iddagt*, the more biomedically-informed stance guides them to suggest a set of specific priorities such as periodic testing at clinics or the purchase of the latest therapeutic technologies, practices that aim at curing the disease but utterly disregard underlying social and cultural dimensions. These therapeutic interventions are located at a great distance from the practical vision expressed by both of them in their less formal discourse. Physicians can afford to neglect their practical visions because they have

enhanced access to treatments available inside and outside the country.

Dr. Samir's critical views, which are inspired by deep involvement with people's everyday lives, sound similar to Dr. Khalil's informal ideas. But issues of class, profession, and poverty make them different. The theme of poverty is central to Dr. Samir's remarks and in spite of his ironic and pessimistic vision of social research, he regards it as a research priority.

Dr. Samir's thoughts are profoundly informed by his immensely perceptive observations of an everyday social reality and his involvement with, and concern for, life in his city. Yet some of the broader aspects of his critique of qualitative research and some of his doubts about different public projects and policies albeit framed rather differently echo the statements of Dr. Khalil and Dr. Mustafa.

Dr. Khalil drew upon a neatly structured paradigm that allowed him to speak about generalized rules that could consequently be applied to different individual cases. This well-structured biomedical model and the prestige and power it currently enjoys permits Dr. Khalil to predict causes and prospects of increased blood pressure regardless of the particularities of individual cases. Similarly, Dr. Mustafa only trusts statistical and other quantitative methods of research and representation. In order to represent correctly the Egyptian case, he insisted on drawing on a set of variables based on medical studies that were supposedly universal in scope and relevance. It is interesting to note that both Dr. Khalil and Dr. Mustafa were involved in projects with international ties. Dr. Khalil's was part of a project that was largely of a ready made type, that is, conceived from a distance to the Egyptian medical reality the type of project in which modifications and suggestions by participating local physicians are neither appreciated nor accepted. Dr. Mustafa's project was linked to a national organization that received foreign funding in the form of technical assistance. Neither project, within its respective structural context, accommodated the in-depth involvement and interpretations of the kind that Dr. Samir had so painfully experienced in his earlier work.

Dr. Samir, consequently, had little use for solutions based on such straightforward unilinear inferences and general paradigms. His close observation of individual cases had taught him otherwise: universal categories might be relevant to abstract and universal projects and interests but were of little help in complex everyday medical and social encounters.

I argue that the differences among the views of the three physicians are not simply a reflection of their personal preferences or professional interests. Rather, this contrast points to a larger and deeper discrepancy between national and international projects on the one hand and local needs and problems on the other. Yet this discrepancy cannot be dismissed as simplistic reflections of differing global and local priorities. Dr. Khalil's contextual and shifting views (his garden discourse versus his office discourse) and the underlying tensions and conflicts, as well as Dr. Samir's at times contradictory statements (his critique and simultaneous support of the qualitative, the local, the importance of everyday experiences) bear witness to larger processes of negotiation between different actors, and more importantly one person's shifting positions. Similarly, Salwa considers poverty worth addressing in action and research. She sees the elements related to poverty as the most important question with regard to causation and reproduction of illness. Concurrently, she criticizes existing institutional arrangements because they are structured in a mode that recognizes only certain topics as priorities for research and action.

In order to gain a deeper understanding of the formulation of momentary, permanent, and absolute aspects of individual and institutional discourses, a very detailed study of existing and emerging social, political, and economic structures would be necessary. Case studies as presented here can only illustrate limited contexts within a much larger socio-medico-economic landscape. Nevertheless, after all is said and done, deconstructed, and analyzed, there is no answer to Um Ahmed's question: "So, Mohammed, are we going to benefit from your research?"

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