Sherine Hamdy


In this book Sherine Hamdy examines the debates surrounding cornea, kidney and liver transplants in Egypt, where these operations began to be performed in the 1960s, 1970s and early 2000s, respectively. Hamdy shows that organ failure is usually represented as being linked to specific diseases (such as trachoma in the case of cornea opacity and hepatitis C in the case of liver failure) whose incidence is placed within a broader Egyptian national narrative about hygiene, modernity and national health campaigns. For example, during the campaign against schistosomiasis in the 1960s and 1970s the government recommended that used needles should be sterilized by boiling them in water; it was unknown at that time that the hepatitis C virus is heat-resistant. Hamdy, who carried out most of her fieldwork before the political changes in Egypt in 2011, points to a crisis of authority that affects both the medical profession and state-employed religious scholars. Whereas an older generation of physicians appeared to fit the ideal type of the “doctor of confidence” who upholds religious and “Egyptian” values (p. 36), a younger generation of physicians is linked to abusive practices such as organ trafficking and profiteering. This dichotomous perception, in turn, is connected to the liberalization policies of the Sadat and Mubarak eras, which included the rise of private health care.

The “doctor of confidence” model is pivotal in understanding varying assessments of organ transplantation and brain-death by representatives of the Egyptian state such as Muḥammad Sayyid Ṭanṭāwī (d. 2010), who served as Mufti of Egypt (1986–1996) and Shaykh al-Azhar (1996–2010), and ʿAlī Gumaʿa (b. 1952), who served as Mufti from 2003 to 2013. The different positions advocated by these two scholars, according to Hamdy, are a function of differing assessments of the medical profession and its routine professional practice in Egypt. Ṭanṭāwī, who assumed that physicians generally live up to the “doctor of confidence” ideal, gave surgeons significant freedom to make bioethical decisions about brain death and the clinical procedures used to establish it. Ṭanṭāwī regarded abuses as more or less isolated criminal acts and did not question the basic assumptions underlying the system or its broader consequences, such as the commodification of the human body. By contrast, Gumaʿa raised fundamental questions about the re-conceptualization of the human body in the context of modern medical technology. It is sometimes suggested that these differing views reflect the clash between brain-death as a “secular, western” concept of death, on the one hand, and cardiac arrest as a “religious, Islamic” under-
standing of death, on the other. This is not true according to Hamdy who, in a revealing passage about debates in Germany in the 1990s, points to fundamental parallels between German secularists who criticized the brain-death criterion and the position adopted by Guma’a.

Public scandals about organ theft had a significant impact on Egyptian debates over organ transplants in the 1990s. Critics of the transplant system focused largely on the marginalization and exploitation of the poor, situating their criticism within the frame of a patriarchal medical discourse in which dissident voices were linked to the “ignorance of the masses,” that is to say, the masses’ ignorance of medical matters. However, Ṭanṭāwī, who defended the transplant system, extended the ignorance label to include “ignorance of religious values.” He situated organ donation within a discourse of religiously commendable generosity.

In the core section of Hamdy’s book, she scrutinizes opposition to Ṭanṭāwī by the extremely popular Shaykh Shaʿrāwī in the 1980s, as epitomized in the latter’s statement, “Our bodies belong to God.” Over several chapters, Hamdy analyzes the multiple layers of meaning attributed to this maxim from different perspectives. Shaʿrāwī argued that decisions about life and death, as well as the transplantation of organs of the human body – which, in his view, belongs to God – should not be made by humans. By contrast, medical practitioners invoke Shaʿrāwī’s statement less as a matter of religious doctrine than as a way of expressing their dissatisfaction with the limitation of the ethical debate to the clinical setting, at the expense of broader social issues such as justice or equity. From the perspective of the individuals (and their families) who must make a difficult decision about whether or not to have a transplant, Shaʿrāwī’s statement may express a wide range of the complex emotions that arise as this decision is being made. Hamdy convincingly argues that the “gift of life” rhetoric, which lies at the heart of strategies used to legitimize organ transplants, relies heavily on trust in medical institutions—often lacking in Egypt. In addition, the “gift of life” metaphor fails to address the anxieties of the recipient of, e.g., a kidney, who may fear living with an unpayable moral debt to a family member, and for this reason perhaps prefer buying an organ from an unrelated donor.

Hamdy argues that it is necessary to broaden bioethical deliberations. Bioethics as a discursive field is largely dominated by an approach in which bioethical problems are analyzed only in relation to the clinical setting and are therefore best solved by means of medical technology. The objective of bioethical deliberation is perceived as being to produce – quickly, if possible – a clear-cut decision about the way in which medical technology should be used in a particular situation. This clinical approach is critiqued by Hamdy, who points