inconsistencies in the quality, style and intention of the essays. Some contributors content themselves with quite straightforward empirical narrative; others have felt theoretically (or speculatively) more ambitious. Scholarly authority is likewise occasionally uneven. In this respect, however, the principal fault often does not lie with the individual authors. A number of contributors (Hall, for instance, Charles Webster on the welfare state, Joel Howell on hospitals) have been fortunate enough to be allocated subjects upon which they have already researched and published extensively. Some of the essays are on events or episodes upon which we have a reasonable historical perspective (Michael Worboys on tropical medicine is a good example) because they took place largely in the first, rather than the second, half of the twentieth century. A few authors have, however, been asked to take up the challenge of areas of historical research in which both they and the medical history community as a whole are comparative novices. Thus Cantor makes many thoughtful observations about the 'Diseased body', but he is unable to offer much in the way of convincing general conclusions. Not his fault, as I say, just a reflection of the overall state of scholarship. Warwick Anderson, on the 'Third world body', likewise sets out an agenda for further research. It is inevitable also that, despite the range and scope of the essays, one can readily point to lacunae. There is, for example, no chapter on the history of medicine itself (although there are some interesting remarks in the introduction) nor one on medical sociology. Thus the rise of learned discourses that are about medicine but not wholly of medicine—surely a notable, and virtually a distinctive, feature of the twentieth century—is not described.

In conclusion, one can virtually unreservedly applaud the ambition and achievement of *Medicine in the twentieth century*. By any reasonable standard, it constitutes a magnificent historiographical accomplishment. It will, I have no doubt, be a fixture on library shelves and student reading lists for several decades of the twenty-first century. But it is telling that, in Chapter 1, Pickstone does not fully address the other major research question he poses, namely how best to describe twentieth-century medicine in terms of the perspective of a longer history of medicine. Thus, as far as the definitive historical character of twentieth-century medicine is concerned, one must concur with the proverbial Chinese Sage—it is too early to say.

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Robert B Baker, Arthur L Caplan, Linda L Emanuel and **Stephen R Latham** (eds), *The American medical ethics revolution: how the AMA's code of ethics has transformed physicians' relationships to patients, professionals, and society*, Baltimore and London, Johns Hopkins University Press, 1999, pp. xxxiv, 396, £45.50 (hardback 0-8018-6170-5).

In 1997 the American Medical Association and the Center for Bioethics of the University of Pennsylvania organized a conference to celebrate the 150th anniversary of the AMA's 'Code of ethics'. The twenty chapters of this volume, first given as papers at that conference, assess the significance of the AMA Code in the history of American medical ethics, discuss current issues of professional medical ethics in the US, and outline likely challenges to biomedical ethics in the future.

In the literature on medical professionalization the AMA Code of 1847 has often been characterized as a self-serving document, written for and by doctors, or as a piece of medical etiquette copied from Thomas Percival's *Medical ethics* (1803). Robert Baker and Chester Burns argue against this position by

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highlighting the principle of reciprocity and the tacit contract between doctors, patients and Jacksonian American society that underlie the Code. Baker, in particular, sees in it a revolutionary change from a character-based personal medical morality to collective responsibility and professional conduct. One of the questions raised in this volume is how the Code was affected by medical specialization in the late nineteenth and early twentieth centuries. Another is what role the Code and its successors, the AMA's 'Principles of medical ethics' (1903, last revision 1980) and 'Fundamental elements of the patient-physician relationship' (1990, updated 1994)—all reprinted in an appendix to the book—can play in the American health care system of today.

As chapters by John Harley Warner and Rosemary Stevens make clear, by 1900 the AMA Code had come under heavy attack from within the medical profession itself. Urban specialists such as the New York City ophthalmologist Cornelius Agnew and the Manhattan paediatrician Abraham Jacobi revolted against the Code's consultation clause that excluded homeopaths and other "irregulars". Warner places this conflict in the wider debate about the role of science in medicine and the notion that scientific expertise rather than traditional codes of conduct were fundamental to professional integrity. The consultation clause was in fact not carried over into the 1903 'Principles'. The challenge of specialism became also manifest in the debate over "fee-splitting", i.e. underhand payments from the specialists (often surgeons) to the referring physicians. As Stevens observes, the AMA battled in vain against this practice until well into the 1920s. In this period, as Susan Lederer points out in a chapter on medical ethics and the media, the Hippocratic Oath rather than the AMA Code, and issues such as abortion and euthanasia rather than conduct between practitioners, dominated public perceptions of the medical profession.

However, an essential feature of both the Hippocratic ethos and the AMA Code was the doctor's unwavering commitment to the welfare of the individual patient. It is this aspect that gives the AMA's ethics their topicality and importance in the current American debates over the system of "managed care" and allocation of scarce resources—a point that is forcefully driven home by Edmund Pellegrino and taken up by several other contributors. While Pellegrino rejects a need for a "new ethic" that accommodates economics and commerce, others seek solutions for the conflict between a utilitarian, population-oriented health care ethics and the old unflinching loyalty to the sick individual. Eliot Freidson envisages in addition to the doctor's "practice ethics" a new "institutional ethics" in which the costs and profits of the pharmaceutical, medical technological and health insurance companies and of managed-care organizations are put under public control. Arthur Isak Applbaum develops the rather disturbing scenario of "practice positivism" in which some medics will no longer have a fiduciary relationship with their patients, but act as contract staff of profit-oriented health-care providers. These medics would no longer be called "doctors" and enter contracts with consenting "customers" (not "patients"). Christine Cassel discusses a model of the physician as a "prudent purchaser" and manager of limited health care resources on behalf of his patients. Robert Tenery, by contrast, sees the way forward in bringing patients themselves into the decisions on allocation and access to health services, e.g. by making them fiscally responsible for part of their own care.

A question closely related to that of what kind of medical ethics we should have in the twenty-first century is that of who should determine its scope and contents. Whereas Mark Siegler argues the case for clinical ethics backed up by empirical

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studies on the doctor-patient encounter, Robert Veatch defends the role that philosophy and theology have had in bioethical discourse and decision-making since the 1960s. Intermediate positions are developed by Alexander Capron ("socially situated, interdisciplinary medical ethics that seeks to protect professional judgement") and by Stephen Latham and Linda Emanuel, who emphasize that the very term "pro-fession" means literally "speaking-forth" or an avowal, which implies the doctor's commitment to the community and the prevailing social ethic. In a similar vein Charles Rosenberg urges that ethics in medicine must focus on the tension between "the structural and the individual", and Paul Root Wolpe, from a discussion of alternative medicine, points to the cultural contexts of medical practice.

In chapters on the future of biomedical ethics Albert Jonsen and Arthur Caplan agree that widespread genetic testing and new genetic therapies will pose major challenges to the concept of patient autonomy. Yet, from a global perspective, as Florencia Luna and George Annas remind us, much work still remains to be done to establish respect for patient autonomy in the first place as a safeguard against doctors' involvement in human rights abuses. Doctors' obligation to the individual patient as expressed in the AMA Code will thus remain highly relevant.

On the whole this volume gives a good example of how a discussion of the history of medical ethics can provide the grounding for a well-informed debate on present and future problems in professional ethics and health care.

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Virginia Berridge, *Health and society in Britain since 1939*, New Studies in Economic and Social History, Cambridge University Press, 1999, pp. viii, 133, £19.95, $39.95 (hardback 0-521-57230-4), £7.95, $13.95 (paperback 0-521-57641-5).

This book reviews data and sources on change in health services and the wider environment since 1945. Most welcome is the critical study of contrasting conclusions and approaches and the broadening of the debate to cover issues about change in professions and in public attitudes to health. The NHS appears more as reacting to forces outside its control than as shaping society's response to health issues.

The book combines chronological history with focus on themes, opening up the period from the 1950s to the 1990s as "virgin territory for health historians". The introduction has a useful summary of demography which stresses the effect of reduced fertility and lower infant mortality rather than ageing itself in reducing the population balance. The book continues with a review of the impact of the Second World War on health. This showed decline in the first half of the war and improvement in the second half: but war did not create any consensus on health policy and it was left to Bevan to create a new dynamic through the nationalization of the hospitals and the exclusion of both local government and insurance interests from health services. This left a service in which neither consumers nor local democracy had much power. "The insurance-based systems established in other countries at the same time may have been more expensive, but they also gave greater influence to workers in maintaining the standard of service."

The account of 1948–74 is the best in the book. There is a particularly useful description of how different client groups fared with a strong drive to bring childbirth into hospital and with no clear policy lines at the end of the lifespan. Elderly patients emerge as the clearest losers from this period with slowness to develop effective community care. There is a good account of change in profession with the decline of the medical

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