may have been far more beneficial than the nurses assumed. It also is possible that nurses who felt insecure about their own competence were especially likely to send neighbours home.

Although visiting nursing in the United States is associated overwhelmingly with the immigrant poor, Buhler-Wilkerson notes that the major employment opportunity for early-twentieth-century graduate nurses was private duty work in affluent homes. She also discusses how contemporary notions of race shaped the interactions between white visiting nurses and black patients in both Charleston and Philadelphia.

An especially fascinating chapter focuses on Lillian Wald, the New York City nursing leader who coined the phrase "public health nursing" and established the Henry Street Settlement, which she directed for many years. In 1911, the Settlement's nursing staff numbered fifty-five, and made more than 175,000 home visits. One of Wald's most remarkable achievements was to convince the Metropolitan Life Insurance Company (MLI) to offer a home nursing benefit. By 1913, that company provided 20 to 30 per cent of the annual budgets of many visiting nurse associations. Buhler-Wilkerson concludes, however, that the MLI's involvement in home care offers a "cautionary tale". The company's focus on cost containment occasionally distorted the nurses' work; moreover, several studies failed to support the claims that the nursing benefit helped to save money by reducing mortality rates. In 1950, the MLI finally discontinued the nursing service. Although various communities experimented with Coordinated Home Care Programs during the following decade and a half, home health care had to await the enactment of the Medicare Program in 1966 for a substantial infusion of funds.

Despite the current deinstitutionalization of medical care, home health services continue to be relegated to a marginal place in the health care system. Buhler-Wilkerson suggests that one reason may be that visiting nurses have historically focused on the poor and the chronically ill, two groups that command little social respect. The isolated settings in which such nurses work also may contribute to their undervaluation. By making visible the enormous contributions of visiting nurses in the past, this book helps us recognize their indispensability today.

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Klasien Horstman, *Public bodies, private lives: the historical construction of life insurance, health risks, and citizenship in the Netherlands 1880–1920*, transl. Ton Brouwers, Rotterdam, Erasmus Publishing, 2001, pp. 211, €27.00 (paperback 90-5235-156-2).

Klasien's Horstman's study explores the relationship between the Dutch medical profession and the life insurance industry during the formative period of insurance medical practice. She rejects established approaches, which account for doctors' roles as gatekeepers of insurance funds either as an aspect of growing professional autonomy, or as the outcome of increasing scientific expertise. Instead her conceptual framework is the interdependency of the profession, the insurance business and the public, although it is the life insurance companies which emerge as the dominant partners. These firms utilized medical science both to further their economic aims, of attracting applicants and selecting healthy risks, and to validate their claims to an ethical, rather than nakedly commercial, social role. Doctors, she suggests, readily surrendered the shaping of insurance practice to the companies, largely because their professional organization, the NMG, was insufficiently concerned with "monitoring activities for public care arrangements" (p. 192). For the ordinary citizen the experience of life selection contributed to a cultural shift in attitudes to the body, in which health came to be seen no longer as a matter of destiny, but of long-term risk, and therefore subject to prediction and to preventive action. Thus life insurance was deeply implicated in the emergence of "homo hygienicus" with his "individualist, rationalist health morality" (p. 155).

The book begins by charting the rise of the Dutch life insurance industry and the early debates about the necessity of medical selection. Horstman shows convincingly how an advisory role distinct from family practice emerged, due both to the industry's desire for objective risk assessment, and to the NMG's concern that medical assessment by family practitioners breached patient confidentiality. The central sections deal with the broader implications of insurance work for medical practice. In her account of medical examination she shows that company worries about the reliability of doctors' assessments led to an increasing standardization of the examination code and recourse to "objective" procedures such as urine analysis. Here she echoes the argument of Marguerite Dupree, whose study of Scottish life examinations pointed to a transition from diagnosis founded upon the patient's narrative to dependence on scientific measurement. The destructive effect of life work on the traditional relationship between doctor and patient was also evident in the demise of professional secrecy, when the NMG resolved, in 1910, that practitioners could inform companies of cause of death. Doctors' expectations that this co-operation would have public benefits, in the form of mortality statistics or industry sponsorship of periodical medical examinations, went unfulfilled. Indeed Horstman's closing sections indict the companies for abandoning the ethical principles they initially espoused, and for fostering a culture in which health risk was understood as an individual rather than a collective responsibility.

There are two areas in which fuller contextualization would be helpful. First, despite the importance to the analysis of the life companies' strategic decisions, little is said about their business history. Matters such as their membership statistics, their range of policies and their fluctuating profitability are consigned to footnotes (p. 63), while the mortality and morbidity regimes in which they operated are dealt with only cursorily (p. 31). Second, it is surely difficult to consider the impact of life insurance in isolation from mutual health insurance. Scholars estimate that by 1920 some 23 per cent of the Dutch population had sickness cover, including, for many, medical assistance. It would therefore be interesting to know whether this played an equally significant part in transforming the public role of medicine in the Netherlands.

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Kirk Jeffrey, *Machines in our hearts: the cardiac pacemaker, the implantable defibrillator, and American health care*, Baltimore and London, Johns Hopkins University Press, 2001, pp. xiii, 370, illus., £33.00 (hardback 0-8018-6579-4)

Whilst the identification of progress in medicine with the introduction of one sophisticated piece of medical technology after another is self-evident for many and a source of concern for a few, there are not many historical studies that shed much light on the processes involved. Kirk Jeffrey's careful and detailed work, focusing on the emergence and deployment (largely in the USA) of two related technologies, the cardiac pacemaker and the implantable defibrillator, is one that does. The first prototype pacemakers emerged at a time, between the two world wars, when neither clinical practice nor knowledge of cardiac arrest could accommodate such a device. Nor were the material and electrical technologies on which such a device necessarily depended then up to the job. The pacemaker that, in the late 1950s, did begin to find a place in medical practice was a very different device from that we now know. It was initially conceived for emergency resuscitation of hospital patients suffering ventricular standstill. The notion of an *implantable* pacemaker came later, and this device was developed, more or less simultaneously, in many places. In each of them collaboration between cardiac surgeons, defining the requirements that would have to be met, and engineers, was central. Gradually, some of these designs succeeded in attracting