Faculty of Accident and Emergency Medicine was established in 1993, it was not until 2003 that the specialty gained full control over its own training programmes, exams, and entry requirements. Most of the book is concerned with detailed descriptions of individual battles lost and won in this long process. In the latter chapters of the book, Guly goes on to describe the implications for the specialty of changes in pathology, work patterns, and medical practice over the last thirty years. In particular, he singles out the expanding role of the A&E in primary care, increased acuity of medical problems, a relative decrease in trauma, limited availability of GPs out of hours, and an aging population.

As Guly himself points out, his book has a narrow focus. It does not set out to examine the progress of the specialty in other countries, nor is it intended to address the larger questions of relations between health care demand, demographics, economics, technologies, etc. It is not intended as a social history of A&E, nor as a theorization of disciplinary formation. Rather, it is an internalist history dealing specifically with "the battle to get the specialty recognized" (p. xiii). As such, it is a careful documentation of precisely that. It should be of interest to practitioners within the specialty of A&E, and of value to those involved in research on emergency medicine, the NHS, and the development of disciplines in general.

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Thomas Schlich and **Ulrich Tröhler** (eds), *The risks of medical innovation: risk perception and assessment in historical context*, Routledge Studies in the Social History of Medicine, Abingdon and New York, Routledge, 2006, pp. xv, 291, illus., £80.00 (hardback 0-415-33481-0).

The footnotes to this book make interesting historical reading. Most of the references to innovation are to works from the early 1990s and most of the references to studies of risk are to books and articles that appeared quite recently. Innovation studies probably came out of concern with interest in new technologies and how they were validated; interest in risk possibly comes from evidence based medicine. There is a huge body of work by experts on risk. In recent years, however, a rich alternative literature has grown up discussing the ways in which risk has become restricted to a technical term or defined only scientifically and thus excludes concerns about safety and danger expressed by ordinary citizens. These issues are helpfully touched on by the authors in their introduction, which is much more broad and useful than the common, ritual recitation of contents. For the most part, the fifteen essays in *The risks of medical innovation* show awareness of these concerns although with varying degrees of engagement.

Almost all the studies are case histories and most are from the twentieth century. The range is impressive. After a chapter by Ulrich Tröhler on a number of innovations since 1850 there are essays on tuberculin, X-rays, radiation, drug treatment for hypertension, hormones, the pill, cancer trials, biotechnology and thalidomide. Four essays in particular took my attention and for three different reasons. Christian Bonah's study of the introduction of BCG vaccine into France and Germany between the wars is a splendid account of the role of the expert and authority in defining risk. What Bonah nicely shows is how, in quite different ways, statistical, laboratory and clinical authority were drawn upon or refuted in different contexts as the objective basis for the efficacy or otherwise of the vaccine. The strength of Thomas Schlich's paper on fracture care is that it explores the cosmologies of the different authorities who claim to be the legitimate identifiers of risk. He discusses two groups of surgeons: those who promoted fracture plating and saw themselves as scientific, and those who promoted traditional traction and described surgery as an art. Behind these representations, Schlich argues, were defences of two social formations: on the one hand the democratic and on the other the personal and hierarchical. From this perspective, different accounts of risk become ultimately incommensurable.

Two papers on apparently dissimilar subjects explicitly shared a dimension that the rest of the volume only hints at. Ian Burney's chapter on

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anaesthesia and surgical risk in Britain in the nineteenth century, and Silke Bellanger and Aline Steinbrecher's study of brain death in Switzerland 1960–2000 might not, at first sight, seem obvious candidates for twinning. Yet a moment's reflection reveals them both to deal with a state that is a dangerous border zone where uncertainty can prevail. After the introduction of chloroform anaesthesia, proponents and opponents argued over the ways in which perceptions of risk of death when the agent was used changed the actual risk, since anxiety and fear were held to be predisposing causes of chloroform's effects. In short, they came to radically different conclusions about the risk of employing the drug. In Switzerland, in recent history, doctors tried to establish objective criteria for brain death to minimize the risk of removing an organ for transplantation from someone who might otherwise recover. Gradually it became apparent that the communication of risk between medical staff and relatives was constitutive of the perception of that risk itself. The interesting question is whether the psychological constitution of objective risk demonstrated in these two important essays is an anomaly because of the grey area they deal with or, in much more subtle ways, is present in all risk assessment.

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Daniel Callahan and **Angela A Wasunna**, *Medicine and the market: equity v. choice*, Baltimore, MD, Johns Hopkins University Press, 2006, pp. x, 320, £23.50, $35.00 (hardback 0-8018-8339-3).

The last century witnessed enormous changes in the context of health care. At the beginning of the twentieth century the most important health problems were those associated with the deaths of infants and children and the consequences of infectious disease. In the developed world, these problems have receded, and much more attention is now devoted to the prevention and treatment of chronic conditions and the prolongation of life at older ages. These changes have placed increasing demands on the capacity of national health care systems to meet their users' expectations, regardless of whether the systems in question are publicly-funded or market-led. However, despite this, much attention continues to be paid to the role which markets may or may not be able to play in meeting future health needs.

This book examines the role of markets in the provision of health care in both developed and developing countries over the last hundred years. It starts by presenting an overview of the role played by markets in the development of health care since the late-eighteenth century, before proceeding to offer a series of detailed surveys of the relationship between markets and the state in Canada and the United States, western Europe, and different parts of Africa, Asia and Latin America. It then offers a detailed account of how the pharmaceutical industry helped to promote market-based approaches to health care, before attempting to summarize the value of market-based ideas and seeking to identify the shape of future trends. Although the authors claim that their sympathy for market-based ideas increased during the period in which they were writing this book, they nevertheless conclude that "the market ... has a potential only at the margins of government-run systems" (p. 245).

One of the book's most important features is the attention it pays to the provision of health care in developing countries. During the 1980s and 1990s, the World Bank and the International Monetary Fund persuaded many of these countries to introduce market-led reforms, but the results—as Joseph Stiglitz has pointed out—were rarely encouraging. However, although Callahan and Wasunna recognise that the introduction of these reforms often led to a deterioration in the standard of health care in many parts of the developing world, they also insist that these countries need to "find a balance" between the state and the market, and that some degree of inequality in the health care system may be a necessary price to pay for the achievement of economic growth. Unfortunately, however, they offer relatively little guidance as to how this price might be calculated.