body and its sensibilities led him to believe that it was impossible to disassociate sensibility from the living principles of the body without adverse consequences. Hickman gave credence to a physiological state in which consciousness was suspended but respiration and circulation continued. It marks a notable shift in understanding. The radical nature of the experiments is underlined by the criticism Hickman received in 1824 and later, in 1828, when he attempted to promote the technique to Charles X and the Paris medical community. His early death in 1830 caused both his name and work to fade from view until the early twentieth century, despite attempts by Thomas Dudley and Hickman's wife, Eliza, to win him recognition in the 1840s.

This slim volume does not pursue the deeper historical significance of Hickman's experiments but it does comprehensively chart everything known about his life and family to date, and reproduces correspondence and extracts from his pamphlets. It forms just a small part of a larger manuscript that was in preparation by W D A Smith at the time of his death in 2002. Fellow members of the History of Anaesthesia Society used Smith's material to create this book as a way of paying tribute to "his lifetime devotion to anaesthesia and pain-relief". They have served him well. Historians of anaesthesia will be enthusiastic about this book; it may also stimulate further research on the wider questions surrounding Hickman's work.

Stephanie J Snow,
Centre for the History of Science, Technology & Medicine,
University of Manchester

Henry Guly, *A history of accident and emergency medicine, 1948–2004*, Basingstoke, Palgrave Macmillan, 2005, pp. xviii, 183, £45.00 (hardback 1-4039-4715-5).

A history of accident and emergency medicine, 1948–2004 traces the development in the UK of that specialty. "A&E is a curious specialty" in that whilst most specialties originated out of increasing sub-specialization, A&E was born out of the need to provide immediate and broad coverage of acute disease and injury in all body systems (p. xii). The author, Dr Henry Guly, has been, over the last three decades, a central figure in this developing area of health care, having held a consultancy in A&E since 1983. Drawing on the archives of the Royal Colleges, the British Association for Emergency Medicine, and other involved bodies—and on his own participation in and considerable personal knowledge of events—he meticulously documents the struggles within the NHS, with other specialties, and within the specialty itself, which gave rise to A&E as a medical specialty and the A&E as a health care institution.

Guly begins by reviewing the state of casualty services between the 1948 founding of the NHS and the Platt report of 1962. The *Report of the Standing Medical Advisory Committee on Accident and Emergency Services* by Sir Harry Platt is cited as the crucial point at which "casualty" services began to be reconfigured around a more specific concept of "accident and emergency". In the 1950s, postings in casualty departments were unpopular, and staffing was through rotas of attending GPs, house surgeons, and casualty officers with joint appointments in other specialties. Throughout the 1960s, orthopaedic surgery, general surgery and anaesthesia vied, often quite robustly, for leadership in this area of health care. However, in 1966, Senior Casualty Officers formed the Casualty Surgeons Association (now the British Association for Emergency Medicine). Familiar with the reality of the A&E, where care involved not only trauma but medical, paediatric, psychiatric and social problems, Senior Casualty Officers recognized that such work required specialist expertise not encompassed by any one of the traditional specialties. They lobbied for the creation of A&E positions within hospitals at the consultant level. Between 1971 and 2001, A&E became the fastest growing specialty in the UK, with consultant positions increasing from an initial 32 to just under 500. However, the battle for control of the specialty by its own members was a long one. Though Edinburgh established an FRCS in A&E in 1981 and, in England, a

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.

John Tercier,
Lancaster University

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

https://doi.org/10.1017/S0025727300001319 Published online by Cambridge University Press