other writers driven by the agendas of cognitive neuroscience, is the meaning of reference to "psychology", "neurophilosophy", or "neuroscience" in the early modern period. In spite of the enormous attention to historical scholarship, books like this one have no intention of being side-tracked by the question whether the categories in terms of which we assemble knowledge are themselves historical constructs. Ultimately, this book takes the modern scientist's view that real knowledge is knowledge of brains, not culture. How historical meaning relates to the modern world of scientific meaning may be a more problematic question than even this deeply informed book allows.

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Moscow

Faye Getz, *Medicine in the English middle ages*, Princeton University Press, 1998, pp. xiv, 174, £21.95, $32.50 (0-691-08522-6).

This book demonstrates the tension that currently exists in medical historiography between a conventional, Whiggish approach to the "rise of the professional medical doctor" and a realization that other theoretical approaches have rather more to offer in terms of the understanding of medicine within the context of particular times and cultures. In her preface, Faye Getz refers to the anthropological work of Levi-Strauss who argued that the medical practitioner "did not become a great shaman because he cured his patients; he cured his patients because he had become a great shaman" (p. xi). This promises an interesting new approach to the study of the healer in medieval society, but she goes on in a more conventional fashion: "[m]edical learning in medieval England from about 750 to about 1450 is the focus of this book, and the central argument concerns how this learning, understood as the medicine that was written down in texts, gained an audience among English people. The struggles of learned physicians to establish a reputation for themselves and for their medicine ... and ... to develop an audience for medical learning, especially among the elite of later medieval English culture" (pp. xi–xii) indicate the primary focus on academic medicine and elite patrons.

The main text opens with a vignette of the death of Hubert Walter, Archbishop of Canterbury (d. 1205), while attended by two physicians, one of whom, Gilbertus Anglicus, is the subject of a previous study by Faye Getz. She argues that Gilbertus' role at the sick man's bedside was not to save his life, but to use his skills, including his knowledge of astrology, to "recognize that death was unavoidable, and that the life of a great man must be shepherded to its end with ritual and dignity" (p. 4). Thus Gilbertus confines himself to advising the Archbishop on when to make his confession, his will, and to receive the last rites.

This intriguing, though problematic, image of the physician as the non-medical determiner of fate and smoother of the passage of the soul, has potential for resolving problems which have traditionally faced understanding of clerical involvement in medicine. However, at this point the analysis is not developed. The nod to anthropological theory having been made, the rest of the book is a far more conventional discussion of the range of practitioners working in England, the growth of academic medicine, the range of texts created by English authors, and the emergence (she argues) of the Galenic "regimen of health" as the preferred and non-medical form of health care by the elite and their physicians. This is frustrating as issues which she regards as problems, such as the paucity of graduates in medicine and the frequency with which non-medically trained graduates practised physic on the elite, or the willingness of families to

https://doi.org/10.1017/S0025727300066229 Published online by Cambridge University Press

continue employing physicians who had allowed relatives to die, would have been resolved had she systematically applied her initial insight. The issue was not, as she says elsewhere, about appropriate medical knowledge or setting standards of care, but about the care of the soul in its physical setting, a job which might be done as well by an educated priest with a smattering of medical knowledge, as by a trained physician. Indeed her own emphasis on the "regimen" as a route to health which did not require doctors implicitly makes the same point.

This is a solid, scholarly work, but it would have been better had the author thought through the implications of her initial analysis.

Princeton University Press might also notice that the stitching is so poor in my copy that after one reading the first quire has already come loose.

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Alan Derickson, *Black lung: anatomy of a public health disaster*, Ithaca and London, Cornell University Press, 1998, pp. xv, 237, illus., £22.50, $22.95 (hardback 0-8014-3186-7).

In the nineteenth century the hazards of coal mining were well known to occupational health specialists. Thus, Thomas Arlidge, that doyen of British occupational medicine, observed in the 1890s that "[m]iners as a rule, are not well-set-up-men". They looked anxious and prematurely old; they had a tendency to shuffle with a stooping gait and frequently had misshapen limbs. Aside from the risk of accidental death or injury from explosion, roof fall, or a range of other perils, they faced various health hazards including nystagmus, ankylostomiasis, and respiratory disease. As regards the latter, Arlidge accepted that coal dust, largely on account of its rounded structure, was not the most dangerous dust. On the other hand, its prolonged inhalation did produce dyspnoea, chronic bronchitis, and fibrosis. Accordingly, while the overall mortality rate among coal miners was surprisingly low, the death rate from respiratory disease was high. As for the widespread notion that coal dust accorded immunity against pulmonary tuberculosis, Arlidge was a confirmed sceptic.

Notwithstanding the state of specialist knowledge at the end of the nineteenth century, the fact is that in the USA, as Alan Derickson convincingly demonstrates, for "much of the twentieth century, many in positions of authority held that breathing coal mine dust was harmless, or even beneficial, to human health". This being the case, few efforts were made in any states either to provide compensation for coal miners incapacitated by their unhealthy workplaces, or to eliminate dust from mines. Indeed, as mechanical power was applied to the extraction of coal in the course of the twentieth century, the dustiness, and hence the unhealthiness, of underground conditions increased. *Black lung* tells the story of how compensation and prevention measures were first denied and later established, both at state level and, eventually, though not until the late 1960s, federally. In the process, coal workers' pneumoconiosis (CWP) came to be accepted as a clinical and compensable condition. Importantly, there was to be a presumption that respiratory disease in miners was of occupational origin.

This is a comparatively short volume which, nevertheless, covers a great deal of ground, including in terms of the growth of scientific, technical and medical knowledge, in all of which areas British researchers exerted a substantial influence in the USA. But it is with the social, legal, and political struggles, particularly of the 1960s, that Derickson is mainly concerned. His story is one in which mining companies, physicians,

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