

intractable health culture designed to encourage rather than reduce a cultural fascination with drugs, in spite of any rhetoric to the contrary, including “wars on drugs”. Moreover, Rasmussen argues that socio-political conditions in the US exacerbate inefficiencies in a health-care system that consistently ranks poorly in terms of national expenditures. His critique of free market health care exposes the irony of American cultural assumptions regarding the essential role that drugs play in maintaining a healthy society.

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Alex Mold, *Heroin: the treatment of addiction in twentieth-century Britain*, DeKalb, IL, Northern Illinois University Press, 2008, pp. x, 236, \$49.00 (978-0-87580-386-9).

Drug law reformers in North America have often held up the “British system” of heroin maintenance as a model for a more humane drug policy. But in this nuanced history of addiction treatment Alex Mold shows that while doctors and policy-makers in Britain were more open to maintenance than their US counterparts, abstinence-based treatment has also had considerable appeal. The “British system” never really existed, at least not in the form envisaged by drug law reformers.

Until the 1960s, Britain had a small number of middle-aged addicts, most of whom became addicted through medical treatment. Doctors were permitted to prescribe heroin to these patients, although in other respects the drug laws in Britain were similar to those in North America. In the early 1960s, a small group of younger, recreational drug users emerged and successfully obtained very large prescriptions from a few doctors. This led to the creation of specialized Drug Dependence Units (DDUs). The psychiatrically-oriented DDUs moved away from prescribing heroin. Instead, following the American example, they provided methadone. Although a study

showed that addicts maintained on heroin were more likely to continue attending treatment, and less likely to commit crimes than addicts on methadone, burned-out staff saw methadone as a step towards getting off drugs. As time went on, DDU doctors largely abandoned methadone maintenance, preferring short-term withdrawal therapy in addition to psychiatric treatment.

In the late 1970s, heroin addiction increased rapidly creating long waiting lists at the DDUs. Many addicts were frustrated by the conservative prescribing practices of the DDUs and what they saw as patronizing psychiatric treatment, and they began to seek treatment from general practitioners (GPs). Mold argues that GPs trained in Britain in the 1970s and 1980s had been encouraged to see patients in terms of their social environment and life histories and, as a result, were more open to maintenance therapy. But DDU doctors and some policy-makers were uneasy about this new development. Ultimately Ann Dally, a prominent critic of DDU practices, faced two General Medical Council tribunals in 1983 and 1986/7 for over-prescribing and medical negligence. But the penalties she received were small, and Mold argues that the Dally cases can be seen as a minor victory for maintenance.

The Dally cases coincided with the emergence of HIV/AIDS among injection drug users. In response, Britain introduced needle-exchange programmes and strove to make treatment programmes more accessible. There was a renewed openness towards maintenance therapy, and users began to play a role in policy-making. Since the mid-1990s, the drug issue, which has increasingly been defined as a drug/crime issue, has assumed a much higher political profile and there has been an enormous expansion of treatment facilities and options. New legislation allows police to drug-test people charged with robbery, begging and other offences. Those convicted of their crimes are frequently given the opportunity to go into drug treatment instead of serving time. So, once again, there is a mix of “treatment” and “control” in the British response to drug use.

This carefully argued book is well-integrated with the existing historiography. Its focus on treatment will appeal more to medical and policy historians than to social historians, as there is very little about the addicts themselves. I was left wondering why heroin use increased so rapidly in the late 1970s. Who were these new users and why did drug use appeal to them? I also wondered why Mold focused only on heroin treatment when by the 1980s most of the drug users were poly-drug users. Is this because doctors and policy-makers focused only on heroin? Were treatments provided for other drugs? Given the increased complexity of drug use around the world, which Mold refers to in her conclusion, it would have been helpful to learn more about how Britain has faced the challenge of treating poly-drug users.

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Colin L Talley, *A history of multiple sclerosis*, Healing Society: Disease, Medicine, and History Series, Westport, CT, Praeger, 2008, pp. xvii, 201, £27.95, \$49.95 (hardback 978-0-275-99788-5).

Colin L Talley's *A history of multiple sclerosis* will find itself on the shelves of many of the estimated 2.5 million people worldwide with multiple sclerosis (MS), in medical schools, history departments and health activists' offices. The intended readership is wide and it does deliver. Based partly on his PhD research, Talley has written an accessible and relevant history.

His main argument is that institutional contexts have been vital in enabling the changes in our experience of MS as disease and illness. His particular assertion is that, if we wish to improve the lot of people with MS, history tells us that the solution lies in state intervention—the provision of increased disability allowances, improved legislation and enhanced funding of biomedical research.

Like the only other monograph on this subject, by the neurologist-historian T Jock Murray, Talley's begins with the emergence of MS from the disease category paraplegia, the nature and location of Jean-Martin Charcot's studies, and the numerous attempts to explain the cause, occurrence and course of MS. Much of this is familiar. Murray's focus was upon physicians and scientists, whereas Talley brings to the fore the social and cultural context. In the latter half of the book Talley approaches the history of the illness experience. Based on the medical literature and patient records (from hospitals in New York and Los Angeles, and Tracy Jackson Putnam's private practice), his argument is that despite equivocal evidence, physicians, encouraged by their patients, have been therapeutic activists. Talley also asserts that the (American) National Multiple Sclerosis Society put MS on medical, public, political and philanthropic maps, and to great effect. MS research funding boomed.

He continues with a review of the secondary literature of disabilities studies, premised on a social model perspective of disability, to make his case for the role of the political economy in enhancing the experience of disability. In particular he highlights the inherent historical bias against the young and female disabled. In the penultimate chapter Talley brings his historically informed argument to the biomedical politics of today. With his customary plain English, he weaves together the science of an auto-immunity framework, an explanation of how interferon(s) modulate the immune system, and an analysis of where and with whose money this basic and applied science was carried out.

Talley explores the long trajectories of MS contingent upon collective and political construction, avoiding esoteric language and swathes of methodologies from the scientific, social science and history disciplines. From his introductory medical description of MS through to a succinct explanation of grounded theory and a closing reiteration of the potentialities of reframing (an auto-immunity) paradigm, his argument throughout is clear.