

Throughout the chapters Aronowitz repeatedly comes back to ‘risk states’: experience of being at risk for disease. As he puts it, it is at once ‘a state to be avoided and worthy of prevention itself’. Jolie’s story can be understood as an example of risk interventions aimed at preventing risk states. Furthermore, her activism can be seen as part of what Aronowitz terms as modern cancer survivorship, the complex and varied ways in which risk-reducing interventions have shaped personal and aggregate patient experiences, including previvorship, an effort to do away with risk altogether and return to a state of certainty.

Aronowitz is very clear on why all this matters and not only voices criticism of health policies, and pharmaceutical and clinical practices, but also puts forward alternative solutions. Among others, he suggests the establishment of new types of regulatory bodies that would more closely scrutinise research and screening technologies that might diffuse practices without proof of efficacy or evidence. While focusing on the United States in general, the book also engages with global health policies and practices by considering global circulation of risk interventions. Through a vaccine controversy involving an international NGO and the unexpected success of an HPV screening and treatment method in India, Aronowitz shows the tensions between risk interventions that are thought to be universal, and local health conditions, and economic and political conditions.

With approaches from multiple disciplines such as sociology, anthropology and history, and drawing on personal experiences as a physician, Aronowitz’s book offers a critical perspective of the expanding centrality of risk in medicine and its effects on public health systems, clinical practice and disease experience. In this sense, Aronowitz’s work is part of emerging scholarship on the centrality of risk in science and medicine, and complements recent publications on risk in the history of science such as Dan Bouk’s *How our Days became Numbered*. The book is, therefore, both relevant and an important read for historians of medicine and science, economists, public health policy makers and medical practitioners.

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Erika Dyck, *Facing Eugenics: Reproduction, Sterilization and the Politics of Choice* (Toronto, Buffalo and London: University of Toronto Press, 2013), pp. xi, 304, \$29.95, paperback, ISBN: 978-1-4426-1255-6.

Internationally, sterilisation is by far the most well-known facet of eugenics, and this contribution to the literature considers applications of the relevant law in the western Canadian province of Alberta. A total of 2822 individuals were rendered infertile under the provisions of the Sexual Sterilization Act, which came into force in 1928 and was repealed in 1972. To gain a sense of perspective, Denmark, a country with a population roughly twice that of Alberta, sterilised 12 735 people between 1929 and 1968. Since fewer than 200 individuals were operated on in British Columbia and no other province had similar laws in place, we may conclude that Canada’s experiment in negative eugenics was of smaller magnitude than what obtained in Scandinavia. Canada’s sterilisation programme was also much less virulent than that of the United States. The end result, however, amounted to exactly the same for the individuals who lost the ability to conceive. A strength of this book is the focus on named persons. Each chapter is based around a

particular case history, two of which, the cases of Doreen Befus and Leilani Muir, became causes célèbres in Canada. Befus has taken up patient activism, while Muir successfully sued the Alberta government for almost a million dollars in 1996. Other cases in which men are the subjects, prove that sterilisation in Alberta was not principally directed at women, as it was in Scandinavia.

The book is interesting and contains findings which will be of use to scholars beyond Canada. For instance, Dyck contends that the sterilisation programme was not targeted at indigenous people in its early days. This was because the eugenists believed that Native Canadians would die out anyway. Only when this proved to be unfounded in the late 1960s, did the sterilisation programme seriously begin focusing on First Nations and Métis communities. Nevertheless, the familiar pattern whereby ethnic minorities were disproportionately affected also holds true for Canada. Aboriginal people represented 2%–3% of Alberta's population but 6%–8% of the total number of sterilisations. Among Caucasians, Eastern European immigrants were more likely than other groups to be sterilised. Although Anglo-Saxon middle-class norms made up the basis of Canadian identity, even settlers from Britain were sometimes viewed with disfavour.

It should be stressed that many of the sterilisations were initiated with the express approval of the patient as a means of permanent contraception. A laudable aspect of the book is that it weaves threads of abortion, contraception and sterilisation together in a unified whole. This leads to a more nuanced understanding of the facts. It is likely that *Facing Eugenics* will establish itself as the standard work on sterilisation in Canada, supplanting a handful of articles. That is not to say that it covers all aspects of eugenics.

As in other national contexts, support for sterilisation and eugenics was not limited to the conservative sections of society. The feminists of the United Farm Women of Alberta (UFWA) supported greater rights for women generally. The political party to which they belonged had been in power since 1921, and in 1923 the UFWA advocated a sterilisation law for people with learning difficulties. Its justification lay partly in the savings to be made in terms of health care and policing and partly in the contemporary belief that paedophilia was caused by morosity. Violet McNaughton, who established many branches of the United Farm Women in and beyond Alberta, was an agrarian socialist. Other organised women also supported eugenics. They were in favour of birth control and wished to use it differentially to extend middle-class values. Eugenics was a relatively new doctrine in the 1920s and seemed to offer solutions to some intransigent social problems.

There are seven chapters and a conclusion, each focusing on a particular aspect of reproductive medicine. These cases show the inherent complexity of the topic as it manifested itself in the period under consideration. They also make clear that family consent for an individual to be sterilised might not be much of a safeguard. Leilani Muir was not on good terms with her parents and many families were either gullible or lacked the resources to challenge the recommendations of doctors. Very interesting is how a Catholic newspaper primarily for German immigrants temporarily suspended its objections to sterilisation in the wake of the Nazis introducing their law for the prevention of hereditarily diseased offspring in 1933. As elsewhere, political Catholics opposed eugenics, though Pope Pius XI's encyclical from 1931 had only castigated sterilisation, not eugenics *in toto*. It was also illuminating to follow the author's argument about how intelligence tests might be administered to patients in asylums with the hidden agenda of obtaining evidence which would allow sterilisation to go ahead.

Dyck is able to write engagingly and objectively about a dark chapter in Canada's history and the controversies surrounding reproductive rights to boot. It is no mean feat

to receive funding from state research councils, to lay the evidence fairly before the reader and to argue that first-wave feminism was influenced by eugenics. The book gives the impression of being truthful and not having been written to satisfy prior opinions or motives. Given the amount of work that has been done on American eugenics, it is mildly surprising that a book on this topic has not appeared until recently. It complements Angus McLaren's *Our Own Master Race: Eugenics in Canada, 1885–1945*, published as long ago as 1990, but the bibliography reveals that there is considerable scope for further monographs. Dyck is forced to rely on an undergraduate thesis and a master's thesis for some crucial information. This is hardly a weakness; it only reinforces the same point about there being space for other studies.

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Margaret Humphreys, *Marrow of Tragedy: The Health Crisis of the American Civil War* (Baltimore, MD: Johns Hopkins University Press, 2013), pp. xiv, 385, \$34.95, hardback, ISBN: 9781421409993.

The sesquicentennial of the American Civil War has generated a good deal of reflection on the impact of the war on American society at large, from the powers held by its federal government to how Americans conceive of and manage death and disability themselves. Margaret Humphreys was well ahead of this curve, first evaluating the social factors at play in the differential health of black versus white soldiers in the Civil War in her 2008 book, *Intensely Human: The Health of the Black Soldier in the American Civil War*. In *Marrow of Tragedy*, Humphreys not only relates how both north and south responded to 'the health crisis of the Civil War', but realigns the very historiography of American medicine by demonstrating the unexpected impact of the war on the delivery of health care in America.

The Civil War indeed represented a health crisis, with neither side initially prepared for the war-related injuries and disease that would ultimately leave more than a million Americans dead. In response, both north and south created a network of hospitals, ranging from truly ad hoc field hospitals all the way to enormous general hospitals built in large cities behind battle lines. While both sides drew from the lessons of Florence Nightingale and the Crimean War, building such general hospitals in accordance with the pavilion model and maximising ventilation, the north (epitomised by Philadelphia's Satterlee Hospital, with its own library and entertainment for its convalescing patients) was able to dedicate far more resources – food, medicine, nurses, even guards to prevent desertion – than could their southern counterparts (epitomised by Chimborazo Hospital in Richmond).

Broader disparities in both prevention and care stemmed not only from the differential organisation and economics of northern versus southern society, but from the efforts in the north of the United States Sanitary Commission (USSC), organised to bring the health-promoting components of home – food (especially antiscorbutics), supplies, the very insistence on not defecating where one ate – to camp. The USSC was not without its critics, especially those opposed to its centralised paternalism and maternalism. And the USSC's comparative assessments of southern versus northern prisoner-of-war camps (highlighting the horrors of those of the south, while publicly downplaying the privations encountered in the north) reveal its own capacity to subjugate its ideals to the pragmatic needs of both the north's and its own survival. But the USSC's efforts to bring the cleanliness and order of