

Book Reviews

transplantation, so interdependent in clinical practice.

It is an exciting story. As medical students in the 1950s, we were told by Professor Max Rosenheim, who later played a substantial role in examining cross infection in dialysis units, about the transplantation of a kidney between two identical twins. We were warned that to fail to ask the potentially life-saving question about the existence of such a twin would lead to failure in finals. Within a single generation of doctors, the diagnosis of acute or chronic kidney failure has changed from a death sentence into a requirement for careful but optimistic life planning. Cameron lays out the many steps and blind alleys in the development of this new technology, where advances could occur in one of many countries, and communication between workers in the same field was not always good. The interplay of personalities and the varying approaches worldwide make fascinating reading, as do the insights into problems from the patients' perspective. Advance was dependent on new materials often developed for quite different reasons, such as those used for membranes and shunts. Improved methods of analysis such as flame photometry and better understanding of physiological issues such as electrolyte balance were essential in clinical care.

Today dialysis appears so routine that we may forget that clinical problems and uncertainties still exist. This book provides a salutary reminder that dialysis itself created clinical conundrums not apparent until those with renal failure lived longer. Emotional problems mattered, for many would come to wish to end their dialysis. Patients were at high risk of suicide, heart attack and blindness. There were syndromes previously unknown such as toxicity from aluminium in the water used for dialysis, and bone and joint pain from amyloid as microglobulins were removed inadequately by dialysis. Then there was the problem of anaemia, largely solved by erythropoietin, and the susceptibility of staff and patients to hepatitis.

Cameron discusses how the financial structure within which health services operate influences the clinical nature of the care patients receive.

Some systems such as the NHS, partly for economic reasons, have placed great emphasis on ending the need for dialysis by transplantation, freeing resources for other patients. Others have been content to expand dialysis services seemingly without limit, driven by commercial imperatives. None have been able to avoid the problem of explicit or implicit rationing.

As well as clinicians, other medical historians—such as myself—will find this book a treasure trove in both its contents and the way in which the curtain is drawn back on the complexity of clinical advances. Few are made by an isolated genius. Too seldom do clinical disciplines have a well-recorded history and Cameron's book could serve as a pattern for others. Indeed, this book goes beyond history and could help those concerned with policy development and clinical practice.

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NDA Kemp, *'Merciful release': the history of the British euthanasia movement*, Manchester University Press, 2002, pp. vii, 242, £42.50 (hardback 0-7190-6123-7), £14.99 (paperback 0-7190-6124-5).

In the 1990s, the case of Tony Bland, one of the victims of the Hillsborough stadium disaster, highlighted the issue of non-voluntary euthanasia. However, in Britain at least, the history of euthanasia has attracted only limited attention. That gap is now filled by Nick Kemp's book, which examines the euthanasia movement in this country, from its beginnings in the 1870s to the present day.

In the introduction, Kemp explores the religious and philosophical origins of the concept, and explains why there was no organized movement before the 1870s. A recurring theme is the ambiguity of the term: euthanasia has also embraced the killing of mental defectives. Another is the need to distinguish between what doctors intended, and the unintended consequences of the application

Book Reviews

of pain-killing drugs. In the 1870s, the debate was primarily philosophical rather than medical. Nevertheless, the discussion drew on technological advances such as chloroform; ideas about a person's comparative worth; the fashion for social Darwinism; and palliative care. Similarly in the early 1900s, Kemp links proposals for euthanasia to the contemporary vogue for eugenics—though he is always cautious about the exact relationship between the two.

One of the strong points of the book is that it fills in the “missing link”, and explores discussions of mercy killing in the period 1910–30. Kemp argues convincingly that the First World War strongly influenced views on death. But again euthanasia embraced both mercy killing for the *compos mentis*, and non-mercy killing for the mentally defective. In the 1930s, the Voluntary Euthanasia Legalisation Society was centred on the Midlands city of Leicester, where, as earlier, euthanasia was linked to perceptions about the rising incidence of cancer. Kemp argues that opposition to the 1936 Bill was based on objections to the altruistic dimension and fear of a “slippery slope” type argument. The effects of the Nazi euthanasia programme are seen as critical to the failure of the 1950 Bill, although Kemp is also appropriately cautious about the links between Germany and Britain in this period. At the same time, he provides an important discussion of non-voluntary euthanasia from 1941.

In contrast, the 1950s were a “difficult decade”, when progress was hindered by an effective opposition, an ageing membership, the loss of leaders, and by developments in palliative care that seemed to offer an alternative to euthanasia. Ironically, the euthanasia movement recovered in the 1960s, mainly because of more consistent leadership, shortcomings in palliative care, and advances in medical technology. Debates in this period reflected the 1961 Suicide Act, but also drew on the experiences of the thalidomide tragedy and on-going debates about spina bifida. Rather than doing too little, medicine was now seen as doing too much, and there was more focus on the quality rather than the quantity of life (p. 186). Even so, the

1969 Bill was unsuccessful, making euthanasia something of an exception to other liberal legislation of the 1960s.

Kemp summarizes some of these themes in the conclusion—the problematic nature of the term; the link between cancer and euthanasia; and the relationship with eugenics—but also provides an overview of debates from the late 1960s to the present day, looking at religious attitudes, the legal position, and medical practice. What emerges is that, despite occasional prosecutions, hastening the death of the patient has become increasingly common (p. 221).

Overall, this is a thoughtful, fluently written, and convincingly-argued book that combines careful research with a brisk pace. Kemp is particularly good at relating debates about euthanasia to wider intellectual, medical, and technological developments. Throughout, this history of ideas is illuminated by some of the vivid and moving letters written by parents prosecuted for killing their children. The volume is a considerable achievement, and deserves to be widely read.

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Terrie M Romano, *Making medicine scientific: John Burdon Sanderson and the culture of Victorian science*, Baltimore and London, Johns Hopkins University Press, 2002, pp. xi, 225, £29.50 (hardback 0-8018-6897-1).

The big puzzle that this book poses, but never entirely solves, is what was it about John Burdon Sanderson that made the Cambridge physiologist Michael Foster think that he had “maggots in his [Sanderson's] head” (p. 132)? On the surface Sanderson had all the right credentials for Foster to be complimentary rather than unpleasant. For a start he was well-born. He came from a strict Evangelical family that straddled the middle class and the minor gentry and had connections with the aristocracy. He studied medicine in Edinburgh for four years between 1847 and 1851 where he was fortunate enough to be instructed by John Hughes Bennett and