at the same time fundamental public criticism of it and a need for alternative therapies (cf. pp. 319f.). Labisch sees two ways out of this situation: a new concentration on medicine as an art that deals with human beings, and permanent ethical self-contemplation.

This comprehensive and concise history of health in the modern period can contribute to a better informed and more objective debate on the future role of medicine in society. It is an example of the practical functions that medical and social historiography may have today.

Andreas-Holger Maehle, Wellcome Institute

HOWARD BRODY, MD, *The healer's power*, New Haven and London, Yale University Press, 1992, pp. xiii, 311, £18.95, $32.50 (0–300–05174–3).

In 1961 one survey found that over 90 per cent of doctors in the USA would not tell patients that they had cancer; in 1979 another survey found that the situation was reversed and that 90 per cent would now disclose the diagnosis. Such a total reversal of policy might suggest that a primary aim of medical ethics had been accomplished: patient autonomy had triumphed over medical paternalism. Nevertheless, this conclusion is more illusory than real, Howard Brody argues in his new book. Much power remains with the doctors, and they can best transfer some of this to patients by fine tuning how much is said and how it is said, for example, against the many clues that arise during the doctor-patient interview.

The central ethical problem in medicine, then, Brody argues, is the responsible use of power. Though, accidentally, the word has rarely been used outside the social sciences, there is a real danger that power used against the disease will come to be diverted against the patient's best interests as well. Brody's solution is to develop sharing of power, using the "conversation model" developed for informed consent, in which patients are involved in medical decisions in an informed way to an extent that they wish. As would be expected from his earlier extensive work on the placebo response, Brody (who is director of the Center for Ethics and Humanities in the Life Sciences at Michigan State University) pulls in a variety of sources for his wide-ranging discussions—from literary works dealing with medical power to "neon ethics" (the much publicized classic cases of ethical dilemmas, such as Nancy Cruzan, Baby Doe, and so on). Two particularly unusual and contemporarily relevant chapters are those relating to power and cost control, and the doctor's income. In the former he concludes that, besides promoting shared care, the health maintenance organizations offer the best model for balancing patient advocacy, cost containment, and quality care—though in the USA some form of centralized and streamlined administration also appears inescapable. And in the second, 'The physician's income', he argues for the existence of two major problems. Firstly, the gap between the income of any doctor and his patients creates a power disparity between them; secondly, the wide gap between the income of the primary care doctor and the specialist—whereby today surgeons earn 90 per cent more than general and family physicians—has also disempowered patients by discouraging doctors from entering primary care. Powerful and often densely written, this book must form a major contribution to the debate about the pattern of health care in the USA once the authorities there have decided what their aims and objectives are to be.

Stephen Lock, Wellcome Institute

KATHRYN MONTGOMERY HUNTER, *Doctors' stories: the narrative structure of medical knowledge*, Princeton University Press, 1991, pp. xxiii, 205, $24.95 (0–691–06888–7).

It is a modern clinician's conceit, and let us hope a temporary one, that medicine is a precise science in which truth equals provability. Hunter's book thoroughly dismantles this belief, asserting that medicine is in fact a "science-using, judgement-based practice", characterized by "varied and ingenious defenses against uncertainty". At the heart of the problem of medical "science" lies the necessity to transcribe the individual patient's experience of illness; to make a doctor's story out of the patient's own.

Hunter prowled the wards and seminar rooms of three North American hospitals (not identified) in her search for the thread of narrative which ties illness to treatment. Her book first details the nature

of medical narrative and the doctor's presentation and charting of the patient's story. She then discusses the status and role of anecdotes, single-case reports, syndrome letters and clinico-pathological conferences. She closes with a plea for the restoration of narrative in clinical care.

For medical historians, especially those who track the history of diseases and disease concepts, Hunter's comments on the nature of clinical uncertainty and of narrative evidence will be illuminating. We are right to admire men like Jenner, Lister and Asher, whose successful disease concepts were constructed directly from the narrative of single cases, collected together. It is easy to misconstrue illness; as Pfeifer did with his discovery of *Haemophilus influenzae* in 1892.

One minor point. Hunter reminds us that "70 to 90 percent of the time a good clinician makes the diagnosis from the history" and adds in a footnote, "this is statistical medical folklore: widely believed, probably true, but unproven". The use of the word "unproven" is doubly surprising here. Devotees of detail will recall Hampton and colleagues on this topic.[1]

My main criticism is that she did not find space for patients' stories verbatim. The patient's voice is therefore absent, and Hunter effectively starts her own story from the point at which the admitting clinician presents the case. This intellectual posture is second nature to tertiary care, but untenable in primary care or anywhere else. Nor does she acknowledge the extent (well documented in the published work) to which patients rehearse, discuss and reconstruct their presenting complaint before they ever see a doctor. In one sense, stories of illness have an ancient life of their own, and are persisting cultural echos which find a voice and a shape whenever an individual succumbs to disease. Hunter has shown that doctors must live and work with the uncertainty that this process creates, now as ever before.

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IAIN D. LEVACK and H. A. F. DUDLEY (eds), *Aberdeen Royal Infirmary: the people's hospital of the north-east*, London and Philadelphia, Ballière Tindall, 1992, pp. xiv, 274, illus., £17.95 (0–7020–1666–7).

A volume commemorating the 250th anniversary of an institution which developed from a seven bed "House" into a major teaching hospital aims to be thorough rather than controversial, and the central theme of progress is understandable. Drawing on the contributions of more than fifty people associated with the Aberdeen Royal Infirmary, the editors have indeed produced a solid, yet accessible, account. Chapters providing a historical outline, and on early medicine and surgery could, with an eye to the broader context, have highlighted some unusual features. For although the infirmary was part of the voluntary hospital movement, its directors were initially appointed by the Town Council, it was expected to admit the workhouse sick, its first "Physician and Surgeon" was offered a fee, and it briefly experimented with inpatient charges. An attempt to interpret early statistics on patient treatments might also have been made, for example, in the light of surgeons' suspicions of anaesthesia and Listerian techniques, or the suggested decline in nursing standards for much of the nineteenth century, or the possibility of overcrowding behind the constant additions made to the infirmary fabric.

Circa 1920, plans for the relocation of the infirmary with other local hospitals and research facilities to the Foresterhill site offered an early opportunity to establish a complete city and regional medical centre. The attitude of municipal authorities, suggesting alternately co-operation and veiled competition, influenced the rate of progress towards this objective, and features beyond the personalities of successive Medical Officers of Health might have been considered. Similarly, the motives of the local BMA, which apparently played a vital assisting role in relocation, were worth exploring as professional, sectional interest and a lack of co-ordination of hospital facilities were important features of British interwar hospitals.

A further phase of expansion on the new site began in the 1950s. Framing and implementing the hospital development plan involved arguments to which we are not privy, though these "contributed

[1] J. R. Hampton, M. J. G. Harrison, J. R. A. Mitchell, *et al.* 'Relative contributions of history-taking, physical examination, and laboratory investigation to diagnosis and management of medical outpatients, *Br. med. J.*, 1975, **2**: 486–9.