between poverty and infant mortality, in the case of Birmingham, it was claimed that there was no *direct* connection to poverty. Infant mortality was considered to be primarily the result of ignorance and bad behaviour among the poor. The focus of the campaign was mainly on improving the home environment and the promotion of breastfeeding through education. The campaign upheld existing gender roles by arguing in favour of male breadwinners and criticizing female employment.

In Gothenburg infant mortality was clearly lower than in Birmingham, and thus there was less pressure to make improvements. Nevertheless, medical practitioners lobbied the government for measures to improve child welfare, partly so as to enhance their own professional status. By contrast to the situation in Birmingham, most practitioners in Gothenburg worked in the public health sector and thus had a vested interest in its expansion. The Swedish campaign was to a large extent directed at reducing the relatively high infant mortality among illegitimate children, blaming single mothers and absent fathers. Nurseries and milk depots were supported, making it possible for single mothers to have employment. In the 1920s the campaign shifted to wider sections of society by starting infant welfare centres for all children.

Chapter five discusses how anti-tuberculosis campaigns regulated urban life and legitimized municipal intervention or non-intervention in the housing markets. Gothenburg had relatively high tuberculosis mortality compared with Birmingham. In Gothenburg the efforts were concentrated on isolating tubercular patients in hospitals and on housing inspections. In Birmingham, the poorer areas, characterized by overcrowding and defective housing conditions, experienced higher tuberculosis mortality than the more affluent ones. The dominant policy in combating tuberculosis was not to intervene in the housing market, but mainly to stress the unhealthy attitudes and lack of hygiene among the poor. As was the case in the infant welfare campaign, education was considered to be the most efficient way to combat the disease.

The author sometimes implies that the public health actors had a hidden political agenda for promoting the existing social and economic order. The arguments presented often seem plausible, but it is not always clear whether different elements of the public health campaigns were primarily a product of more or less conscious intentions to reinforce or maintain the social and economic order, or whether they reflected the best efforts to promote health within the given political circumstances. Maybe Niemi could have developed this issue more extensively or discussed possibilities of alternative interpretations.

I was somewhat surprised that eugenic ideas and theories that had a considerable impact on contemporary public health discourse, should have exercised relatively little influence on local public health policies in the early twentieth century. Niemi mentions that Swedish women who were believed to transmit serious hereditary defects were seen as grave threats to the health of the nation and the Nordic stock. Many were sterilized on these grounds, and pressure was put on mothers diagnosed with tuberculosis to place their children in foster care. This issue could also perhaps have been discussed at greater length.

Nevertheless, this book provides valuable insights into the local public health policies in early-twentieth-century Sweden and Britain, and their interplay with political interests, gender structures, science and professional aspirations.

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Steven J Peitzman, *Dropsy, dialysis, transplant: a short history of failing kidneys*, Baltimore, Johns Hopkins University Press, 2007, pp. xxi, 213, £16.50, $24.95 (hardback 978-0-8018-8734-5).

The kidneys have often been the poor relations of other organs in the history of medicine. Hearts, lungs, brains, and reproductive and digestive organs have received much more attention. But, as Stephen Peitzman points out, the kidneys are of such fundamental importance that when they cease to do their job, the other organs do not function properly.

Although nephrology is a relatively new clinical specialty, medical concern with kidney disease has a much longer history. Peitzman's wonderfully evocative history of end-stage kidney disease explores this history with verve and insight. His story proper begins with Richard Bright (1789–1858) and the disease that carried his name until recent times. One of the "Great Men of Guy's", Bright convinced the governors of Guy's Hospital, London, to devote a small ward with an attached laboratory, so he could study dropsy and the other consequences of failed kidneys. He identified the presence of albumen in the urine as a marker of kidney disease, and used both the insights of contemporary chemistry and the pathological orientation of French hospital medicine to describe a "new" disease.

Like many of his contemporaries, Bright dealt in both the ward and the autopsy room with the final results of fatal disease, correlating the findings at autopsy with the clinical diagnosis. Bright's work was subsequently duplicated by other pathologically orientated clinicians and, well into the twentieth century, "Bright's disease" carried specific, grim connotations. Its aetiology remained elusive, and most debate centred around minor modifications of treatment and management.

From the late nineteenth century, new diagnostic procedures were developed, and these, combined with a greater understanding of the physiology of the kidney, led to a reconceptualization of "Bright's disease". Although the eponym disappeared only gradually, doctors recognized that there were many routes to end-stage kidney disease. Management also improved, but the prognosis remained pretty much as grim as it was in Bright's day, with the proviso that doctors realized that in some patients, their kidney failure was temporary and with decent management, they could recover. That put a higher premium on finding ways to keep people alive, hoping that the process that had shut down their kidney function would be a reversible one.

This was the rationale for the early work on dialysis, pioneered in the Netherlands in the horrible conditions of the Second World War. Willem Kolff, the inventor of dialysis, went to the United States after the war, but his first patients were kept alive with varying degrees of success in the stressed social ambience of a Nazi-occupied country. Dialysis can be done in two ways. The common one nowadays is via a shunt in an artery, whereby the blood circulates through the dialysis machine, which removes many of the substances that the kidney ordinarily does. Urea is the most obvious of these. The problems of this form of renal dialysis were mostly technical, especially that of constructing an aterio-venous shunt that could be used without the opening clotting or getting contaminated between dialyses, which need to take place about three times a week.

The other way to dialyse a patient in kidney failure is to place a needle in the abdomen and by introducing appropriate fluids into it, allow diffusion of the waste substances to accumulate in the abdominal space. These are then removed. Peritoneal dialysis, as it is called, takes longer and also has the problems of introducing infection as well the considerable discomfort it causes. It is the kind of dialysis I remember, when I spent a month of my internship tending patients who had had problems with their shunts.

Peitzman pays only modest attention to peritoneal dialysis, since most dialysis since the mid-1970s has been via the machine. He writes movingly about both patients and their doctors in the ménage-à-trois (patients, dialysis machines and doctors), and analyses the curious trajectory of laissez-faire American medicine, whereby end-stage renal disease (ESRD) acquired the right to treatment, at public expense. Creating an entitlement to publicly funded care on the basis of a diagnosis remains unique in the American setting, where so much public medical care is either means or age tested.

Dialysis, even if someone else pays, is a terrible commitment of three or more four-hour sessions each week just to maintain some semblance of normalcy, and there is the constant threat of complications. There are also real problems with renal transplantation, but for many, that procedure offers the best hope for normal kidney function, and through that, normal social life. Peitzman takes his readers through both the science and the clinical and ethical issues of transplantation. As a nephrologist himself, he knows the medicine from the inside, and has great empathy for the patients he has spent his professional career treating. His mix of science and suffering makes for a fine book, always readable and often moving.

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Gino L Di Mitri, *Storia biomedica del tarantismo nel XVIII secolo*, Florence, Leo S Olschki, 2006, pp. xxiii, 322, €34.00 (paperback 88-222-5508-9).

In this history of the medical, biological and social phenomenon of tarantism in the eighteenth century, Gino Di Mitri reconstructs the theories, debates, links and opposing views of savants, European and *Pugliesi* physicians, travellers, healers, patients and musicians at a crucial historical moment. At that time, opposition between the experimental knowledge of local physicians and the theoretical knowledge of academics—of which Di Mitri shows a profound understanding—became more and more relevant to the story of tarantism.

The first chapter presents an historical panorama of the doubts about, and the medical debate on, tarantism from the sixteenth century. Tarantism originated from the venom of the tarantula, but was also a disease simulated by women (*carnevaletti delle donne*) in order to enjoy music and escape the difficulties of family life. Di Mitri widens his research on the European debate of the seventeenth and eighteenth centuries by drawing on the work of Etienne-François Geoffroy, Harald Vallerius and Luigi Desbout. These authors pay most attention to the power of music, considered as a remedy for or antidote to the venom of tarantula.

In the second chapter, Di Mitri studies the links between entomology and medicine at the beginning of the eighteenth century, the debate on the action of the venom of the tarantula and the identification of the spider (*Lycosa tarentula* vs *Latrodectus tredecimguttatus*). As he makes clear, the controversy about the real or simulated effects of tarantism was centred in experience. Physicians from Puglia, where the disease was widespread, testified that it was a real physical state seen with their own eyes. The original meaning of *autopsia* could be used to show the contrast between those who wrote about the disease only *ex auditu* and those who wrote *ex visu* and because of *didici, reperi, comperi* and so on.

Visual evidence of the disease becomes a major concern in the third chapter, in which the opposing views of two eighteenth-century physicians—Niccolò Caputi and Francesco Serao—are presented as examples of the changes in scientific thought. Di Mitri analyses the life and works of Caputi, a physician active in Puglia (Lecce) and husband of the *tarantata* Beatrice De Cesare. The medical cases narrated by Caputi can be used to show that there was no hiatus between the official medicine of the Enlightenment and the empirical and popular medical practice of music-therapy. But Caputi was a local physician who believed in the real action of the tarantula's venom, while Serao was a foreigner who attributed the disease to the prevailing melancholy of the inhabitants of Puglia. Francesco Serao is the model of the physician who never experienced the disease: he wrote his *Lezioni* in the Neapolitan academic milieu of theoretical knowledge: a