

aspect of anaesthesia—its mode of action, practical applicability, safety and ethics—was widely debated in medical, public and governmental circles. From the early 1860s anaesthetic techniques were a generally accepted, but certainly not unproblematic, part of medicine, surgery and dentistry, and by 1900 the practices and structures of anaesthesia as a medical speciality were firmly established in Britain. Public views of anaesthesia, however, were not so straightforward. Snow identifies a widespread “fear of unconsciousness” in the late nineteenth century: in clumsy or malicious hands chloroform might result in robbery, kidnapping, “violation”, a loss of proper self-control or even death. Such fears informed a more selective attitude in submitting to anaesthesia than the casual observer of this period might at first imagine.

For this reader the most fascinating part of Snow’s book is an analysis, taken from her doctoral research, of almost 4,500 anaesthetics from the casebooks of Dr John Snow, backed up with case reports from several large London hospitals. John Snow’s self-confessedly scientific attitude to anaesthetics is contrasted with James Young Simpson’s more traditional biographical approach to show that, contrary to received wisdom, “scientific medicine” before 1860 was as much a determinant of practice as it was a rhetorical strategy.

Snow’s prose is lucid and expressive, her theses insightful, her conclusions illuminating and well supported. Though neither dental nor military anaesthesia here receive the attention they merit, this is less an omission and more a call to further research in these fields. This book deserves to become both a standard reference work for students of Victorian medicine and a template for future workers in this field. If *Operations without pain* receives the perceptive readership it demands we may expect to witness the beginning of a rewarding new era in the historiography of anaesthesia.

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W D A Smith, *Henry Hill Hickman* Sheffield, History of Anaesthesia Society, 2005, pp. 80, illus., £10.00 + p&p (paperback 0-901100-59-5). Orders to: Dr Adrian Padfield, 351 Fulwood Road, Sheffield S10 3BQ.

What prompted the Shropshire surgeon, Henry Hill Hickman, to carry out a series of animal experiments on suspended animation around 1823? For decades this question has puzzled those interested in the history of anaesthesia and indeed has contributed to the curious pre-history of anaesthesia in which the experiments of men such as Humphry Davy, Crawford Long, Horace Wells and, of course, Hickman, hang as shadows on the landscape.

Hickman experimented at a time when understandings of asphyxia were changing. Once understood as an absolute, death began to be conceived as a process during the eighteenth century and medical research began to focus on resuscitation and the various techniques that could restore life in a body with no pulse or respiration. Thus Hickman knew suspended animation as a form of asphyxia; a state in which respiration had been suspended but life still existed—hence his use of bellows during a seventeen minute amputation of the leg of a dog. It is clear too that Hickman had absorbed the new configurations of the nervous system which emerged from the work of Charles Bell in Britain and François Magendie in France in the 1810s and which supported a separation in the functions of mind and body. Hickman predicated his experiments on the belief that if applied to humans, the key benefit would be the suspension of the mind of the patient and thus the absence of anticipation of suffering, as well as the relief of physical pain. Hickman’s use of the new anatomy and physiology in his quest to alleviate surgical pain makes him pivotal in the wider history of anaesthesia. Writers have often pondered on the apparently inexplicable fact that Humphry Davy’s 1790s research into nitrous oxide did not lead to the development of inhalation anaesthesia. But Davy’s conception of the

body and its sensibilities led him to believe that it was impossible to disassociate sensibility from the living principles of the body without adverse consequences. Hickman gave credence to a physiological state in which consciousness was suspended but respiration and circulation continued. It marks a notable shift in understanding. The radical nature of the experiments is underlined by the criticism Hickman received in 1824 and later, in 1828, when he attempted to promote the technique to Charles X and the Paris medical community. His early death in 1830 caused both his name and work to fade from view until the early twentieth century, despite attempts by Thomas Dudley and Hickman's wife, Eliza, to win him recognition in the 1840s.

This slim volume does not pursue the deeper historical significance of Hickman's experiments but it does comprehensively chart everything known about his life and family to date, and reproduces correspondence and extracts from his pamphlets. It forms just a small part of a larger manuscript that was in preparation by W D A Smith at the time of his death in 2002. Fellow members of the History of Anaesthesia Society used Smith's material to create this book as a way of paying tribute to "his lifetime devotion to anaesthesia and pain-relief". They have served him well. Historians of anaesthesia will be enthusiastic about this book; it may also stimulate further research on the wider questions surrounding Hickman's work.

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Henry Guly, *A history of accident and emergency medicine, 1948–2004*, Basingstoke, Palgrave Macmillan, 2005, pp. xviii, 183, £45.00 (hardback 1-4039-4715-5).

A history of accident and emergency medicine, 1948–2004 traces the development in the UK of that specialty. "A&E is a curious specialty" in that whilst most specialties originated out of

increasing sub-specialization, A&E was born out of the need to provide immediate and broad coverage of acute disease and injury in all body systems (p. xii). The author, Dr Henry Guly, has been, over the last three decades, a central figure in this developing area of health care, having held a consultancy in A&E since 1983. Drawing on the archives of the Royal Colleges, the British Association for Emergency Medicine, and other involved bodies—and on his own participation in and considerable personal knowledge of events—he meticulously documents the struggles within the NHS, with other specialties, and within the specialty itself, which gave rise to A&E as a medical specialty and the A&E as a health care institution.

Guly begins by reviewing the state of casualty services between the 1948 founding of the NHS and the Platt report of 1962. The *Report of the Standing Medical Advisory Committee on Accident and Emergency Services* by Sir Harry Platt is cited as the crucial point at which "casualty" services began to be reconfigured around a more specific concept of "accident and emergency". In the 1950s, postings in casualty departments were unpopular, and staffing was through rotas of attending GPs, house surgeons, and casualty officers with joint appointments in other specialties. Throughout the 1960s, orthopaedic surgery, general surgery and anaesthesia vied, often quite robustly, for leadership in this area of health care. However, in 1966, Senior Casualty Officers formed the Casualty Surgeons Association (now the British Association for Emergency Medicine). Familiar with the reality of the A&E, where care involved not only trauma but medical, paediatric, psychiatric and social problems, Senior Casualty Officers recognized that such work required specialist expertise not encompassed by any one of the traditional specialties. They lobbied for the creation of A&E positions within hospitals at the consultant level. Between 1971 and 2001, A&E became the fastest growing specialty in the UK, with consultant positions increasing from an initial 32 to just under 500. However, the battle for control of the specialty by its own members was a long one. Though Edinburgh established an FRCS in A&E in 1981 and, in England, a