(Pott's disease, named after English surgeon Percival Pott [1714–1788], noteworthy for his work on spinal deformity). The diagnosis was a common one in this period, and until the discovery of streptomycin in 1943 and its effective therapeutic use in 1946, a virtual death sentence. Rasbach notes in his extremely useful 'Medical Afterward' to *The War Outside My Window* that pulmonary tuberculosis killed 'nearly one-half of the young Americans who died between the ages of 15 and 35' (p. 416). LeRoy's slow decline as witnessed in his debilitated weight of sixty-three pounds in November of 1863 shows in painful detail why this was often called the 'wasting' disease. Rasbach's carefully argued afterword will be of intense interest to readers of *Medical History*.

Having said this, it is questionable whether readers of this journal will find Rasbach's companion volume equally engaging. For one thing, after *The War Outside My Window*, it offers little new. The author explains that his reason for writing *I Am Perhaps Dying* is that LeRoy's illness runs like 'a separate dark thread . . . through the diary' (p. xiv). But the reader of the main volume cannot avoid this thread, and the lengthy 'Chronicle of Consumption' (pp. 55–109) consisting of extrapolations from LeRoy's diary seems superfluous. Medical historians will also find Rasbach's chapters on 'The Natural History of Tuberculosis', 'LeRoy's Doctors and Medical Care during the Civil War', 'LeRoy Gresham's Pharmacopoeia' and 'Proprietary or Patent Medicines' familiar ground. His discussion of 'Pott's Disease' is a useful contribution, but why couldn't this material simply have been added to the existing published diary? The substantive additions would have added another fifty pages or so. It seems hard to believe that such an expansion would send production costs soaring, and it would have removed a nagging question from the reader: why, after going through LeRoy Gresham's story (well worth the list price), should I now need to expend an additional $14.95 on what amounts to largely a rehash? Why couldn't the publisher have added Rasbach's useful and interesting medical commentary to the afterword? It seems doubtful that a reader willing to spend $35 on the diary would balk at spending $40 on a slightly expanded version. Having the *complete* story told under one cover would have been a better approach.

As it stands, it simply looks like the publisher is trying to squeeze extra dollars from its customers, a strategy understandable enough, but certainly not appreciated by the public or by librarians having to deal with increasingly tight budgets. While Civil War aficionados and medical historians will appreciate this addition generally, the two-volume approach leaves a bad taste. Like the useless patent medicines Rasbach discusses that were bought to cure LeRoy's ailments, one feels this companion volume was produced more for opportunistic gain than edification. That should not detract from Rasbach's useful medical additions, only from his overzealous publisher. With helpful maps, illustrations of the diary itself and eight very nice black and white plates of the Gresham family (including LeRoy), one volume would have been enough.

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Douglas M. Haynes, *Fit to Practice: Empire, Race, Gender, and the Making of the British Medicine, 1850–1980* (Rochester, NY: University of Rochester Press, 2017), pp. vi + 246, £80, hardback, ISBN: 9781580465816.

As the United Kingdom faces an era of NHS staff shortages in the fallout from the Brexit vote and clampdowns on immigration, Douglas Haynes' volume on the regulation of

overseas practitioners offers a timely reminder that Britain has long pitted its medical needs against its protectionist instincts. Covering the period between 1850 and 1980, *Fit to Practice* examines the global influence of British medicine by charting the thorny negotiations that allowed British practitioners to work abroad, and their overseas counterparts to train in Britain. This sprawling topic is made manageable by a focus on the actions of the General Council of Medical Education and Registration of the United Kingdom (GMC). While the GMC was a neutral organisation charged with 'protecting the public' by maintaining a register of licensed practitioners, this task was often burdened by political expectations and professional pressures. As a result, Haynes shows how the GMC acted as a gatekeeper to 'British medicine' by preserving its largely white, male character – even when selectively permitting foreign and female doctors to cross the threshold.

The first half of *Fit to Practice* charts the spread of British medicine from the passage of the 1858 Medical Act to the domestic medical crisis precipitated by the Second World War. Haynes shows how the concept of 'reciprocity' developed to allow the surplus of British doctors to access local medical markets across the British Empire, with entry onto the British medical register offered to colonial doctors in exchange. For several decades, this offered a form of comparative equality, as doctors were free to practise across national borders – extending into countries such as Japan and Italy as diplomatic alliances were forged. Yet, benefits were only extended to those who held degrees from recognised medical schools and societies, and so long as such institutions held up barriers against women and minorities, so long were they excluded from the arrangement. Indeed, by ensuring that only those medical schools which promoted British medicine abroad – generally through the employment of white British men – the GMC ensured that reciprocity posed little threat to the domestic medical establishment. This system came under strain, however, as several dominions objected to their markets being opened to unwanted outside competition. Britain, too, saw the advantages of limiting access to their register, particularly when managing the flow of foreign doctors in and out of the country during the two world wars. Rather than widening the reach of reciprocity, temporary registration became the tool of choice to prevent refugee doctors from settling in the country. In these opening chapters, Haynes lucidly describes how the British medical community kept their professional interests at the forefront of international practice agreements.

The second half of the book surveys the decades following the Second World War, showing how the independence of India and Pakistan was accompanied by increased restrictions being placed on their doctors practising in Britain. As Haynes argues, concerns about language competency became a proxy for racialised hostilities towards non-white medical personnel, and double standards began to develop in Britain's attitude towards doctors from more and less 'desirable' partner nations. As the cash-strapped GMC became more dependent on support from the medical establishment, they steadily adopted a system where overseas doctors were subjected to high fees, limited registration periods, close supervision and a rigorous admission test to ensure they would remain subordinate to local practitioners. While the GMC continued to recognise the qualifications of most Commonwealth-trained doctors, the emancipation of India's medical schools from British dominance meant that their standards were increasingly suspect. Haynes thus shows that the preservation of 'British medicine' was reflected in the barriers placed on Indian doctors despite a clear need for their labour. Protecting the 'credibility' of the NHS provided a cover for creating a two-tiered system of practice that effectively discriminated against overseas doctors, rendering their positions unstable and futures insecure. While reciprocity

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was only brought to a formal end with the passage of the 1978 Medical Act, its original egalitarian principles had long been corroded by professional and racial anxieties.

Haynes effectively argues that the medical register became instrumental in protecting and promoting a homogeneous vision of British medicine – both by exporting its exponents around the world and by providing access to Britain's medical market only to those who practised in its image. While the first half of the book reveals a great deal about how other countries interacted with a system designed to privilege British interests, by its close the focus is squarely on the GMC's efforts to juggle competing interests in its regulation of overseas medical practitioners. This emphasis undoubtedly adheres to Haynes' introductory description of *Fit to Practice* as an institutional history of the GMC. Yet, the more insular focus of the second half occasionally raises questions that a broader approach might have addressed. It is not clear, for instance, how the South Asian medical community responded to criticisms of their competence, nor what character an emerging 'Indian medicine' was assuming as Britain's influence waned. Despite the title, 'practice' itself receives little attention. If the hegemonic control of white, male elites imbued medicine with any distinct attributes, they are not highlighted. Equally, while race plays a role in the debates over linguistic fluency, gender ceases to be discussed in the later chapters, despite the growing number of women entering the profession. This strand could have enhanced the book's broader arguments about hierarchies and discrimination within British medicine. Finally, case studies might have helped to give voice to those affected by the policies whose genesis Haynes so carefully reconstructs. *Fit to Practice* ultimately emerges as a useful guide for considering how the British medical register became a portal for spreading a particular brand of medicine across the world, and for safeguarding it from outside influence. For those wondering what obstacles have prevented Britain from resolving its domestic medical needs with foreign labour, it reminds us not to underestimate the role of bureaucratic tools wielded by small, tractable agencies.

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William H. Foege, *The Fears of the Rich, The Needs of the Poor: My Years at the CDC* (Baltimore, MD: Johns Hopkins University Press, 2018), pp. 280, paperback, $24.95, ISBN: 9781421425290.

William H. Foege is a distinguished American medical doctor and epidemiologist with extensive field experience best known as the architect of the method of 'surveillance and containment' for smallpox eradication work. This method replaced mass vaccination (efforts to vaccinate a very high percentage of the population), and made possible the eradication of smallpox in the late 1970s. This smallpox methodology was initially designed in Africa in the mid-1960s when Foege had to work with a limited supply of vaccines. He used these resources carefully and intensely only in the most affected villages where it was possible to contain the disease. The method required the prompt identification in homes, markets and schools of individuals exhibiting rashes and the compulsory vaccination of people in and around these locations. The result was that smallpox could be made to disappear with a fraction of the vaccinations required for a mass campaign. By the late 1960s the method was adopted by the World Health Organization