isting substandard housing. Private owners of substandard housing must be given adequate financial and regulatory incentives to adopt environmental interventions that create asthma-friendly housing.

The book concludes with Ayanian and Williams presenting 5 principles for eliminating racial and ethnic disparities: (1) expand health insurance coverage and access to care, (2) promote diversity in the health care workforce, (3) promote patient-centered care, (4) collect appropriate data and monitor performance, and (5) establish measurable goals with accountability for all racial and ethnic groups. These principles are not unique to eliminating disparities but also advance the cause of improving quality of care for all. By espousing these principles, Ayanian and Williams are encouraging policy makers and health care professionals to see the synergy in addressing the problem of health care disparities and the need to improve access to high-quality care in the US health care system.

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WHO OWNS OUR HEALTH? MEDICAL PROFESSIONALISM, LAW AND LEADERSHIP BEYOND THE AGE OF THE MARKET STATE

By Thomas Faunce.
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PROVOCATIVE TITLES FOR BOOKS AND ARTICLES SERVE TO attract the reader and, if effective, also suggest the main thesis of the book. Thomas Faunce, a senior lecturer in the College of Law and the Medical School at the Australian National University, has recently written *Who Owns Our Health? Medical Professionalism, Law and Leadership Beyond the Age of the Market State*. Can you guess the main thesis and the conclusions simply from the title?

The book examines whether the "dominant ethos of profit-making in health care is indeed compatible, in the long term, with one of community service." The book examines the issue using "basic principles drawn from moral philosophy, bioethics, health law, and international human rights." The book includes numerous literary references, particularly to Chekhov, Dickens, and other authors concerned about moral issues.

Faunce has spent several years examining the ways in which drug prices are regulated in Australia and the role that international trade agreements have in establishing drug prices, and he incorporates these findings into the book. Most physicians outside Australia will probably not know that the US government has been trying to get other countries to loosen their regulatory controls on drug prices and allow the marketplace to work. The US government's argument is that regulation of drug prices in other countries artificially lowers drug prices and indirectly keeps drug prices higher in the United States. Clearly, Faunce was influenced by the rancor of this debate in Australia when the US government tried to use trade negotiations to change the way drug prices are set in Australia.

The book's main focus is a series of observations concerning the roles of physicians in the current health care system and how professionalism is being threatened. For example, one of the conclusions of the first chapter is that "the traditional ideals and values of medical professionalism are now being challenged by the dominant influence of the corporate sector and the market share in global health care delivery." This tug-of-war sets the stage for the remainder of the book.

The second chapter establishes the main thesis of the book, specifically that "a health professional, industry representative, or policy maker's response to patient suffering ought to consistently commence with a strong conviction of the need to care." I had 3 reactions to this conclusion. The first is to agree. The second is to remember the recent articles in *JAMA* and elsewhere that have focused on the large number of physicians who obtain financial compensation from drug companies and other corporations. The question is whether this compensation interferes with their "need to care." Faunce would argue that it does. Third, I spend considerable time in Washington, DC, talking to policy makers. One of the things that I notice when physicians come to Washington is that often they do not focus on the benefits that they provide to the community or to their patients but instead immediately focus on the inadequate amounts that Medicare, Medicaid, and other health insurers are paying. Emphasizing the "need to care" is an important role for physicians to remember when they come to Washington.

Chapter 3 argues that "student health, professionals, and policy makers should be taught how the principles of medical professionalism merge with those emerging from the corporate-controlled market state." This is an exceedingly important point and one that is constantly evolving. I have lectured in a course entitled "Physician and Society" at Johns Hopkins Medical School for the past 15 years. To my great chagrin, students increasingly arrive without the "traditional ideals and values of medical professionalism" and increasingly expect to enter a profit-making profession. The book has additional chapters that go into specific topics, such as the role that law plays in the evolution of health care and medical professionalism in armed conflicts. For me, these were important but less interesting topics.

The title and topic of this text immediately captured my interest. The issues discussed are fascinating and cause the reader to examine his or her reasons for becoming a physician or other health professional. For these reasons, the book is worth reading. At the same time, I doubt the book will really convince anyone to change their behavior. The author believes that "a case has been made here for institutional support and encouragement of health professionals (including health corporation executives and policy makers) who seek to achieve virtue through consistently performing actions to relieve such patients' suffering." This is an appropriate goal. However, my guess is that the book will not cause regulators to take a different perspective, it will not convince medical students to take a different path when they enter the medical profession, and it will not change the behavior of practicing physicians. However, this may not be the book's objective.

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TWELVE DISEASES THAT CHANGED OUR WORLD

By Irwin W. Sherman.
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DISEASE HAS INFLUENCED THE COURSE OF HUMAN HISTORY AS much as any force or phenomenon—war, famine, greed, religion, and weather. Maybe more. Plagues in particular have hammered individuals and cultures throughout history. In the superb *Twelve Diseases That Changed Our World*, 10 of the featured maladies are caused by microbes: smallpox, bubonic plague, cholera, tuberculosis, syphilis, influenza, malaria, yellow fever, AIDS, and the Irish potato blight. Hemophilia and porphyria are the only noninfectious illnesses to make the list.

History, science, personalities, and public health are successfully intermingled in this lively book. The result is a chain of adventure stories with all the requisite elements: peculiar scientists and heroic physicians (are there any other kind?), evil bacteria and viruses, overwhelming odds, and a cast of millions. Highlights include vivid descriptions of diseases (notably cholera), flamboyant profiles of scientists, a first-rate discussion of quarantine, and an excellent chapter on tuberculosis. The book's imagery is a treat (coffin ships and rubber-suited sanitarians are 2 examples). Some of the sentences are eye-catching: "But terror and flight have always been plague's handmaids./The pox, if you were unlucky, could rot the organ of manhood."

The chapter on tuberculosis is exceptional. Has any disease been more romanticized? At one time it was considered an erotic and creative illness. It has been linked to an "artistic temperament" and formerly believed to "spark genius." The roster of patients with tuberculosis is lustrous: Chekhov, Kafka, Keats, Orwell, Robert Louis Stevenson, and Thoreau, to name just a few. The author spices his discussion with outdated terminology—galloping consumption, lunger, the White Plague, and phthisis—to conjure up the culture of tuberculosis in a bygone era. Unfortunately, about one-third of the world's population remains infected.

Over the centuries, germs have been used in many nefarious ways. In 1763, during the war between France and England, the British intentionally soiled blankets with matter derived from the pustules of smallpox and then gave these contaminated blankets to discontented North American Indians. Another example of early biological warfare involved the use of "flying corpses." In 1346, a Mongol army leader commanded that dead bodies infected with plague be catapulted over the walls of Kaffa, a city on the Baltic Sea that was under siege. In the 1930s, the Japanese tried to disseminate plague by using airplanes to drop infected fleas into China.

This book contains plenty of additional offbeat tidbits. Both Saint Roch and Saint Sebastian are considered plague patron saints. The Iowa "Cow War" of 1932 pitted angry farmers against veterinarians; cows were slaughtered, and cars belonging to veterinarians were intentionally damaged. *Yersinia pestis*, the pathogen of bubonic plague, can last for years in a frozen body. In the 1800s, adult Irish peasants ate, on average, 9 to 14 pounds of potatoes daily—now that is some serious carbohydrate loading!

Other morsels of knowledge are much more sobering. Someone dies from malaria every 10 seconds, and most of these are young children in Africa. A measles vaccine is inexpensive—the cost of a single dose is as low as 15 cents—yet the disease continues to claim the lives of 450 000 children annually.

Mini-portrayals of scientific celebrities, including Paul Ehrlich, Edward Jenner, Robert Koch, and Florence Nightingale, are integrated throughout the book. More interesting are the vignettes of less legendary disease-busters. Especially impressive are the self-experimenters. Max von Pettenkofer chugged a culture of *Vibrio cholerae*, roughly a billion bacteria, in front of his students. The famous John Hunter died of syphilis many years after he deliberately inoculated his own penis with a droplet from the urethral discharge of a syphilitic patient. You have to admire Hunter's moxie and dedication to science—but yikes!

Any criticism of this book is minor. One quibble is the author's affection for the word "miasma." Do not misunderstand me. It is a good word. Whenever I think of a noxious vapor or exhalation, miasma is always on the tip of my tongue. Still, most might utter or scribble such a word on just a few occasions in a lifetime. "Miasma" wafts 10 times from the pages of chapter 3 alone.

This Working Party, whose membership extended far beyond the Royal College of Physicians, began its task with the assumption that at the heart of good medical care is a set of values, attitudes and behaviours called medical profes-sionalism. Our aims have been to discover what is understood by the concept of medical professionalism today, to formulate a description that can command wide recognition and support, and to make recommendations that we believe will help shape a new medical professionalism as a valued and welcome force in the life of our society.Â Terms of reference of the Working Party. Aim To define the nature and role of medical professionalism in modern society.