tentional disorders? Could ADHD with efficient *COMT* val 158 be treated with COMT inhibitors? Should ADHD patients with the 9-repeat *SLC6A3* allele not be exposed to amphetamines—or should they have higher doses? What, if any, is the relevance of these genomic findings to movement, mood, and thought disorders?

The graphics are dry, but the insightful and lucid narrative style, along with the pervasiveness of amphetamines, recommend the book to an audience of primary care and specialist physicians across the spectrum. I hope its pricing and marketing are such that it will be dog-eared in many physician's personal libraries.

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Health Systems

Remaking American Medicine, Frank Christopher, executive producer, Matthew Eisen, co-executive producer, Marc Shaffer, series producer and writer, four-part television series, premiered October 5, 2006, DVD available for purchase, $29.95, Santa Barbara, Calif, Crosskeys Media; Arlington, Va, PBS, 2006 (http://www.remakingamericanmedicine.org).

THE FOUR-PART, FOUR-HOUR PBS SERIES *Remaking American Medicine*, produced by Crossskeys Media and funded largely by the Robert Wood Johnson Foundation, is focused on efforts to improve the quality of health care delivery that US residents receive.

Episode 1, "The Silent Killer," addresses work being done at Johns Hopkins and other hospitals to reduce medical errors, including those that are fatal. Episode 2, "First Do No Harm," largely explains the pervasive problem of hospital-acquired infections, specifically methacillin-resistant *Staphylococcus aureus*, and efforts among several Pittsburgh hospitals to reduce its prevalence. Improving the continuity and comprehensiveness of chronic care, mainly for diabetes and the prevention of secondary and tertiary symptoms, is the subject of episode 3, "The Stealth Epidemic." The series concludes with "Hand in Hand," which presents the work being done at the Medical College of Georgia's Children's Medical Center to involve parents and family members actively in the care and recovery of children.

Remaking American Medicine provides an eye-opening and at times heartrending introduction to just a few of the many difficulties—actually failures—of US health care delivery today and does so, somewhat remarkably, without disparaging health care professionals. The program certainly lends credence and utility to the notion of patient empowerment. The public is owed programming such as this.

Although the series has been written for the general public, the health care community may benefit even more from watching it. Regrettably, however, its lessons are not as explicit as they might be, since what is actually going on between medical professional and patient—which ultimately defines the quality of health care and its provision—is presented somewhat simplistically and is not explained.

Physicians and other health care professionals may want to pay particular attention to Anne Peters, MD, a Los Angeles diabetologist profiled in part 3. Dr Peters believes that effective treatment means "creating an entirely new relationship with patients," and she understands her work as "embarking on a partnership." One of her patients observes that "traditional doctors tell you what to do," whereas with Dr Peters, "we're in this together." This may sound obvious or even trite, but it is fundamental. Unfortunately, the series misses the opportunity to explain why Peters' highly interactive, social approach makes her health care practice so superior.

Throughout the series, the viewer is told repeatedly that health care delivery (here, namely hospitals) involves complex systems and that for health care quality to be improved, "systems" need to be changed. Thus, emphasis is placed on what should be going on, for example, the hiring of hospitalists, the development of quality improvement collaboratives, and the need to expand the use of health information technology. However, such a system-improvement approach is based on two questioned assumptions: that systems, despite being an abstraction of human interaction, have some inherent properties or meaning; and that health care delivery is largely a systematic or mechanistic and linear process whereby the provider gives care to a passive receiver.

However, it appears that Peters sees her work otherwise. Providing high-quality care to her diabetic patients largely means trying to make sense of a disease condition together with them. Instead of an authoritative and all-too-typical approach used to make patients compliant, Peters' efforts seem aimed at reaching a concurrence of patient and physician. Peters appears interested in both what is true about the patient's condition and, equally, in learning based on the patient's own goals what is most useful in effectively treating each individual. Peters does not seem overly concerned with system limitations but is shown taking time to communicate effectively, using mutual adaptation to create a shared awareness. She has her patients commit to work with her, ultimately leading to their taking control of their own disease. Thus, even more relevant than the health care professional's technical expertise is the ongoing, back-and-forth interactive dynamic of patient and physician. Professional and patient obtain new clinical knowledge via the process of social relating.

Similarly, in episode 1, Peter Pronovost, MD, PhD, a patient safety expert at Johns Hopkins Hospital, is shown working to improve two-way communication between doctors and other professional staff, in part by having nurses fully participate in decision making during morning rounding.

Peters and Pronovost in *Remaking American Medicine* show us the way that individual physicians work with patients to create high-quality health care. The challenge remains: how do we cre-

ate a system that optimizes patterns of interaction to improve the quality of health care delivery?

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History of Specialization

Divide and Conquer: A Comparative History of Medical Specialization, by George Weisz, 359 pp, $49.95, ISBN 0-19-517969-2, New York, NY, Oxford University Press, 2006.

SPECIALIZATION IN RESEARCH AND practice has been a visibly distinctive feature of the biomedical landscape in Europe and the United States certainly since the second half of the 20th century. In this important historical study, George Weisz, PhD, professor of Social Studies of Medicine at McGill University, cogently analyzes the forces that gave rise to specialties and continue to shape their futures. These include the needs of medical research and education, the expanding role of government as an engine in rationalizing health care resources, the politics of regulating new and existing specialties, and the internationalization of training, research, and practice. The compelling nature of Weisz's analysis derives from his impressive grasp of the secondary literature in multiple languages and a comparative framework that illuminates the conditions that defined the path of medical specialization in different national settings.

Weisz lucidly charts the creation of specialists, from generalists with an emphasis to full-time certified specialists, giving attention to the cultural and institutional dimensions of this process. Interest in understanding the body through the lens of specificity emerged within a larger cultural context—first in Paris in the 19th century—that valued the division of labor as a method for two modernizing enterprises: the advancement of human knowledge and the management of populations through classification. In all national settings, medical institutions played an important role in this process. Hospitals and medical schools furnished the venues for treating illness and pursuing clinical research. As such, these institutions and others formed the backbone for nascent and established research communities, whether located in Paris or more diffusely in the state-financed university system in Germany or in public and private institutions in the United States. As centers for the production of medical professionals, they too were influential in legitimizing (or not) the value of specialization. Indeed, the establishment of specialty chairs, space in the medical curriculum, and opportunities for clinical training were occasions for conflicts between gate-keeping elites and specialty advocates.

While there was greater resistance to medical specialization from elites in Britain and France than in Germany and the United States, by the early 20th century all experienced an increase in the number of specialty practitioners. The creation of new journals and societies and greater attention in established venues reflected the impressive proliferation of specialty knowledge and practice inside and outside national borders. Yet, formalizing public and professional recognition through the standardization of training and the certification of specialists was contentious. The stakes were high in Britain, France, and Germany as national governments began to play a more active role in subsidizing medical services for their populations. The different interests (elites and nonelites, generalists and specialists as well as the governments) struggled to reach a consensus between professional self-regulation and state regulation. In the end, Germany and the United States followed the former path; Britain and France, the latter. These paths were political compromises, which preserved the right of doctors to practice medicine while sanctioning the authority of elite institutions, specialty organizations, and national associations to regulate access to the field.

Despite the different paths, the national professions in the United States and Europe exhibited striking similarities during the post–World War II period. The number of specialists and specialties grew significantly in an age of increasing state spending on medical care and research. Growth produced its own consequences. The policy solutions adopted by national governments to rein in costs, as Weisz convincingly demonstrates, involved greater state intervention that infringed or eroded the traditional power of both professionals and career gateway institutions. In varying degrees in Europe, states sought to upgrade the certification requirements of general practice and rationalize the training of specialists. In the more politically fragmented landscape of health care in the United States, "special instruments" of cost containment have been deployed, including managed care, nonphysician replacement personnel, and others.

On both sides of the Atlantic there is now widespread dissatisfaction among specialists and generalists, patients and consumers, and administrators and politicians with the entire health care enterprise. This is, as Weisz judiciously concludes, "one of the by-products of the successful division and conquest of medicine by the forces of specialization that advanced precisely because they were so intimately associated with belief in the possibilities of science, expertise, and limitless progress" (p 256). For those who are interested in contemporary health care challenges, Weisz's book provides essential and compelling historical perspective.

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