GRAHAM MOONEY. *Intrusive Interventions: Public Health, Domestic Space, and Infectious Disease*. Rochester Studies in Medical History. Rochester: University of Rochester Press, 2015. Pp. 278. $125.00 (cloth).
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It seemed only fitting that, on the day a copy of *Intrusive Interventions* by Graham Mooney arrived on my desk, I had been to lunch at the Wellcome Library in London, where some of the research for this book was carried out. Moreover, lunch was with another fellow former student of the late Professor Bob Woods, who supervised the doctoral dissertation from which Mooney developed his book. Woods's legacy of using data in all forms to understand historical population health change, especially in the nineteenth century, shapes this volume in many ways, although I agree with Mooney's assessment that Woods would (as would I) have liked more graphs.

This is a densely written text, full of detail. Mooney begins with an introduction to the intrusions of disease surveillance and control and their relationships with poverty. He then takes us to the late nineteenth-century council meetings, where parties acting for various interest groups argued for and against (and sometimes seemingly both sides) compulsory notification of disease and ensuing isolation. Mooney highlights how disease notification was understood as both a need in disease control and a risk to it, as simultaneously a constraint on liberal rights and a protection of them. The geography of notification was partial and not well recorded. Urban areas implemented various voluntary schemes to greater or lesser extent, with repeated refusal to implement national law giving opportunities to councils to develop and enforce local legislation as they best saw fit. Mooney illustrates how much of the debate was around whether it also should be a general practitioner's or the householder's responsibility to notify disease to their local council. General practitioners were both potentially unwilling to notify diseases of particularly their more affluent patients. There was also some feeling that notification broke the fundamental confidential nature of the doctor–patient relationship. Similarly, the role of the medical officer of health in supporting or resisting the legislation seemed largely (though possibly not unreasonably) out of self-interest based on whether doctors would lose patients from their private practice. The individuals' lives for whom isolation would cause the most disruption (generally the poor) had little voice in the discussions.

Mooney's critique of surveillance flows throughout the book. Landlords were also required to report those with infection lodging with them. The disincentive to do this must have been great even if the landlord could identify the disease and judge it notifiable. The landlord would lose income from the tenant and potentially have to have the lodging house disinfected. Employers were also expected to notify local authorities if employees were suffering infection. And with advent of legislation in the late 1800s making education compulsory, teachers, though ill qualified, were also expected to recognize and report disease. Once disease was reported, isolation was supposed to follow. Similar to the doctors, the teachers relied on pupil attendance to provide school income. Notification of disease and exclusion of pupils limited attendance, disincentivizing teachers to report their pupils as infected even if they were able to diagnose them. On the other hand, this history raises the question of whether particular groups or families were excluded from school by these diagnoses if they were perceived as otherwise problematic as has allegedly happened in contemporary education settings.

Mooney notes that though there was little recorded coerced incarceration, there were cases where those who left the hospital without discharge were viewed as criminals, somehow absent without leave. Patients probably faced other sorts of hidden coercion. The distinction on class grounds for removal of nuisances (a category extended to include people) between those with sufficient space to host a sick room for a notified case and those in small, overcrowded

accommodation where this would not be feasible, was marked. The rights of wealthy individuals, if they did indeed end up in hospitals, included in some cases paying to have mothers in the hospital alongside the sick child. Visitors were generally discouraged if not prohibited unless death was imminent, disrupting for most the traditional model of the family as the locus of care.

Mooney asks the inevitable question: did notification and isolation work? He finds little evidence that these practices reduced mortality or morbidity—just one graph showing lower case fatality rates of those in isolation in hospital. This seems astonishing given the widespread practice and the eventual compulsory national legislation. On a more positive note, these practices did lead to more thoughtful protocols for observation and isolation, and ultimately they led to the development of hospitals funded at least in part through taxation and the state showing responsibility for its citizens' health and well-being.

The detailed history of disinfection described by Mooney was highly mechanized, with new methods evolving with technological and clinical knowledge developing alongside each other. The lack of national guidelines and the rapid advance of science again gave rise to localized variation in practice and enforcement. Finally, Mooney discusses the refocus of the treatment of infectious diseases back to the home and family, as tuberculosis was not amenable to disinfection and the scale of indoor (inpatient) hospital care too great. This exposed the burgeoning middles classes to the marketing of series of tools for treatment and support. The consequence was a move away from government-delivered care toward the market, the individual, and the household.

This is a very detailed history of several key elements of the sanitary revolution and a very good read. As noted above, I feel the reader would have benefited from tables of the timing and locale of legislation in terms of notification, isolation, and disinfection, to get a sense of the diffusion of debate, practice, and enforcement. And a few more graphs would have aided those of us who also wish to use it as a teaching resource.

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Myles Osborne and Susan Kingsley Kent. *Africans and Britons in the Age of Empires, 1660–1980*. Abingdon: Routledge, 2015. Pp. 249. $49.95 (cloth).
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Based on a co-taught course, Myles Osborne and Susan Kingsley Kent's survey of British engagement with Africa from the seventeenth century, *Africans and Britons in the Age of Empires, 1660–1980*, attempts to enliven the story by focusing on the actors. The personalities, contingencies, and complex motives of both African and British individuals, and not the grand designs of a "monolithic empire," are therefore the focus of their study. Each chapter begins with a vignette about one of these individuals and sets out key themes, which include precolonial contact, the Scramble and colonial rule, decolonization, and postcolonial adjustment. This chronological approach is effective, especially for broadening students' understanding of African agency and complicating the picture of colonialism. The structure of the book's chapters would work well as the spine of a course on colonialism in Africa, or specifically on British colonialism in Africa; or it could be useful as a text running alongside others in a broader survey of the British Empire.

The book's structure is as follows. The opening two chapters cover the precolonial period. In the first, Osborne and Kent address the slave trade and move on to abolition and the early settlement of West and South Africa. Here they do an especially good job of synthesizing the historiography of the impact of the slave trade and its abolition on African development. In