did near the end of her life when she was ill. At times, Kiesel references it to show she has caught Dorothy in a lie when information does not match Kiesel's own research findings. Certainly, the task of historians is not to simply celebrate historical figures. However, people are complex and contradictory human beings and the work of historians is to understand them within their personal and historical contexts.

Overall, *She Can Bring Us Home* is an engaging study of an African American woman physician whose deserves to be better known in medical history. In particular, more scholarship needs to be done on Dr. Dorothy Ferebee's work as a physician. In the end, Kiesel's study provides an important reminder of the contributions that some physicians have made to promoting social justice. Medicine was, and still is, a profession that attracts leaders whose interest in addressing health and well-being extends well beyond their private practices. As Kiesel rightly shows, Dr. Dorothy Boulding Ferebee was one of those visionaries.

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James C. Mohr. *Licensed to Practice: The Supreme Court Defines the American Medical Profession*. Baltimore, Maryland, The Johns Hopkins University Press, 2013. viii, 216 pp., illus., \$21.95.

KEYWORDS: public health, medical legislation, allopathic medicine, medical marketplace, Gilded Age, regulation

Seasoned historian James C. Mohr illuminates an understudied aspect of American medical history, the origins of state-enforced medical licensing laws in the United States in a concise, well-written, easy-to-read narrative. It was in West Virginia after the Civil War that the Regular physicians convinced the state legislature to pass the Board of Health Act in 1882. In addition to empanelling a state public health body, the law also vested it with legal power to license medical practice. Despite legal challenges to the Board of Health Act that began almost immediately after its passage, the law was ultimately upheld by the Supreme Court in *Dent v. West Virginia*, a landmark 1889 decision that made West Virginia's system of medical licensing a model for other states. As a result, this decision would underpin the development of health-care regulation and delivery during the twentieth century.

The story of medical licensing in West Virginia is one of personal animosities, political intrigue, contentious legal battles, and even a sensational murder among the state's Gilded Age elites. Many of the physicians in Mohr's account supplemented their incomes by working on retainer for large railroad corporations, positions that linked them to powerful business, political, and legal elites in the state. To further

Regular medicine, public health, and medical licensing, some physicians even entered politics themselves, winning seats in the state legislature that passed medical licensing. Beyond the fascinating narrative, Mohr sets the historical actors against the political, economic, and social context of the Gilded Age to analyze the moment when Regular physicians finally closed a historically open medical marketplace in the United States.

Mohr argues that West Virginia was a logical place for the expansion of state police power to regulate professional practice to take place. Having emerged out of the chaos of the Civil War, West Virginia was a new state that to some degree provided a political and legal blank slate. Leading the licensing effort was physician James Reeves, who founded the Medical Society of West Virginia in 1867 to be a bastion of Regular medicine. An uncompromising Methodist, he undertook the campaign to enact enforceable medical licensing laws as a crusade to purify the “True Church” of medicine (36). Committed to ideals of public health, Reeves and his allies argued that the public needed protection from uneducated and unscrupulous practitioners. State power via medical licensing laws was the solution. Enjoying the support of powerful elites like James Ferguson, a political boss and corporate lawyer, and newly elected West Virginia governor Jacob Jackson, the Board of Health Act became state law in 1882.

Challenges to the Board of Health’s authority to regulate medical practice arose almost immediately. The Dents, a prominent West Virginia family that had a history of disagreement with Reeves and his hardline adherence to Regular medicine, would play a prominent role in the legal battles over the Board of Health Act that ensued during the 1880s. When the Board of Health refused to license Frank Dent on the basis of his Eclectic training, Dent continued to practice anyway. In 1883, he was charged, found guilty, and ordered to pay a fifty-dollar fine. Dent’s attorney and cousin, Marmaduke Dent, a rising legal star in the state, immediately filed an appeal. In 1884, West Virginia Supreme Court of Appeals upheld the lower court’s decision, sending *Dent v. West Virginia* before the Supreme Court.

Marmaduke Dent’s primary argument was that the Board of Health Act, which restricted medical licenses only to Regular physicians, represented an exercise of “arbitrary powers” that “violated due process . . . and equal protection provisions” of the Fourteenth Amendment (111). Attorneys for West Virginia countered with an expansive interpretation of the Tenth Amendment, which guaranteed “virtually unlimited police powers over all matters not specifically assigned to the national government” (119–20). In 1889, the Supreme Court ruled in favor of West Virginia, upholding the medical licensing provisions of the Board of Health Act. Thus, according to Mohr, “*Dent v. West Virginia* provided constitutional ratification of nothing less than the conscious formation of a new profession in the eyes of the law: the licensed physician” (2).

Grounding his analysis in both legal and medical historiographies, Mohr argues that while the American public supported public health efforts to control epidemic disease, medical licensing was not a popular reform. It was instead “a consciously

engineered policy, drafted and passed through the concerted efforts of a specific subset of physicians, the elite Regulars” of the Medical Society of West Virginia (156). Mohr also challenges the interpretation that medical licensing was a response to the growing complexity of scientific medicine. Because scientific medicine did not produce tangible therapeutic results until the 1930s, the push for medical licensing is also a consequence of economic and political factors, not strictly scientific ones. Finally, Mohr shows that the Supreme Court upheld a version of medical licensing that relied on the quality of a physician’s education as the only measure of competence, a system that led to the growth of a massive and costly medical malpractice system.

Mohr’s sources—newspapers, medical society records, personal papers, and legal documents—show clearly that the controversy surrounding medical licensing in West Virginia was more than a “local and specific . . . feud” of “idiosyncratic individuals.” *Licensed to Practice* is the story about a struggle “over nothing less than the future status of the medical profession in the United States,” a “battle” that “forced the nation’s Supreme Court to rule on how the relatively recent Fourteenth Amendment would impact occupational and professional regulation by the states” (155). Mohr’s effective blending of engaging narrative with cogent historical analysis makes this book a useful resource for historians of medicine, legal historians, as well as those interested in social history. But the book is also appealing to medical, legal, and regulatory professionals seeking a historical perspective on medical licensing, its impact on practice, and the implementation of public health in the United States. Mohr’s important contribution is sure to stimulate interest in this often overlooked but significantly important episode in American medicolegal and regulatory history.

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Don B. Olsen. *True Valor: Barney Clark and the Utah Artificial Heart.* Salt Lake City, University of Utah Press, 2015. 432 pp., illus. \$44.95 (cloth).

KEYWORDS: human experimentation, cardiology, medical devices, animal research

Tough to argue that it did not take courage for patient, Barney Clark, to agree to be implanted with an experimental mechanical heart in 1982. He lived a remarkable 112 days with the artificial heart after his own diseased heart was removed. But Clark’s clinical experience was rocky, and he never left hospital. He battled seizures, respiratory problems, a broken heart valve, confusion, and clear mobility limitations due to