Medical Misadventure in an Age of Professionalisation, 1780-1890, by Alannah Tomkins; pp. xii + 290. Manchester: Manchester University Press, 2017, £75.00

*Medical Misadventure* is neither a narrowly-focused view of medical ‘frailty’ nor a broad revision of the history of the Victorian medical profession. Instead, Tomkins uses those themes to shed light on the way in which ‘medical status’ itself was (and is) constructed (p. 24). Tomkins’ exquisite (and abundant) case studies are intricately contextualised within broader cultural and social waves. The ambit is broad, but convincingly held together with a deft narrative. Each chapter explores individually relevant subjects, including bankruptcy, culpability, ambition and madness, but underpinning the whole is an exposition of imperfection, exploring how it functioned in ‘multiple ways’ within the relationship between doctors and patients. Tomkins’ clear passion for the subject carries the reader through what would otherwise be an exhausting tour de force of beguilingly wide-ranging subjects. Although the title is valid, it belies how important struggle, failure and disappointment were to the medical profession for most of this defining period in their history.

Medical practice depends on patient trust; rightly or wrongly the human fallibility of its practitioners is a threat to that dependency. In order for it to provide the greatest benefit to mankind, the Victorian medical profession constructed, encouraged and relied upon a narrative of extraordinary, almost transcendent curative power. Concomitantly this project also created the opportunity for medical human rights abuses against individuals and populations. Tomkins is measured in her appraisal of those abuses, choosing to use selected case studies to throw new light on the entwined tropes of masculinity, medicine and competition in the professional project. Most obviously, medical status has been constructed in the lauding of great men and their achievements while ‘subordinating evidence of their humanity’ (p. 24).

Tomkins’ book brings forward case-study after case-study to remind us that medical professionals are fallible human beings, as much in pursuit of professional survival and personal profit as enriching medical beneficence. The market place, as Tomkins suggests, was not replaced by professionalisation at any time in the nineteenth century (p. 7). The opening chapter thus deals with bankruptcy and insolvency, showing that debt was unexceptional and ever-present for Victorian doctors; moreover, credit was frequently available to medical professionals, despite their unstable income streams (pp. 37-41, 68-70). Bankruptcy was therefore quite rare but by no means reflected nationwide professional successes. Medical men needed to keep up appearances to retain clients, and spending frequently outweighed income. Tomkins further explored this taut financial elasticity in the careers of medical practitioners in the Indian Medical Service. Oft-touted as rags to riches stories, Tomkins’ research reveals that the scale of colonial financial drudgery and struggle was on a par with those in England. Promotion in India was limited and generally only granted to the elder staff – approximately 50-60 per cent of the medical practitioners attempting to build a career there were never going to be promoted (p. 85). ‘The majority could expect death in service or in transit, with restricted prospects for social and financial advancement’ – doctors ‘generally came to realise the limitations of an Indian posting (p. 105).

The public support for abortionists is particularly noteworthy (p. 144). Tomkins’ research here is both distinctive and relevant. Tomkins suggests of Victorian abortion that there were ‘two very distinct accounts’: on the one hand the ‘rhetoric’ of the professionalisation of medicine in the late-nineteenth century and on the other hand ‘a much more pragmatic and domestic one concerning women’s or couples’ attempts to manage their fertility’ (p. 147). Despite outward ‘deprecation of the practice’, medical men met an ever-present ‘demand’. Abortionists were outwardly condemned by ‘their’ profession, but they could carry great weight in the community and received open support from the lay public (p. 144).

Allegations of sexual assault and murder seem to have aligned the public and profession more closely, with a public press that was less than energised in its reporting of medical men charged with sexual offences. There was a contemporary fear that medical men were particularly vulnerable to the imagined vulnerability of the female patient; a fear which was accelerated by use of anesthetics (pp. 161-75). Tomkins suggests that medical men were found guilty of sexual crimes at a greater rate than other professionals even though judicial procedure was at times bent to protect their standing. Both public and profession were not always condemning of the medical sexual miscreant (p. 167) and acquittals were sometimes greeted with applause and cheering (pp. 172-73). Guilty medical men could remain on the medical register (p. 168) and not infrequently they re-established their careers after time-served. As Tomkins observes, the medical profession closed ranks sometimes but there is ‘clear evidence’ that the public collaborated and remained onside with this endeavour (pp. 175, 223-24).

*Medical Misadventure* is essential reading for anybody with an interest in the history of the professions, masculinity and medical professionalisation in this period. Perhaps the most pressing but subtle aspect of Tomkins’ research presents itself in the form of the practitioner ‘Bad apple’ – a process of mythologizing and demonising medical misadventure, which distracts from the ongoing context of human frailty and weakness (p. 187). Despite this actuality, the unequal relationship between doctors and patients has historically remained sacrosanct. Certainly, medical practice itself would be better informed if medical students were to engage with this work and its relevance to the impact of their own human failings. As Tomkins suggests, ‘Recognition of practitioners past and present as human beings first and medical practitioners second will serve to alleviate the pressures imposed by presumptions of skill and authority from both within and outside the profession. Unrealistic expectations in the twenty-first century are in part a product of nineteenth-century handling of evidence for falling short’ (p. 24).

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K. Price, *Medical Negligence in Victorian Britain: The Crisis of Care under the English Poor Law, C. 1834-1900* (London and New York: Bloomsbury Academic, 2015)