

‘A Wicked Operation’? Tonsillectomy in Twentieth-Century Britain

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Abstract: Histories of twentieth-century surgery have focused on surgical ‘firsts’ – dramatic tales of revolutionary procedures. The history of tonsillectomy is less glamorous, but more widespread, representing the experience and understanding of medicine for hundreds of children, parents and surgeons daily. At the start of the twentieth century, tonsillectomy was routine – performed on at least 80 000 schoolchildren each year in Britain. However, by the 1980s, public and professional discourse condemned the operation as a ‘dangerous fad’. This profound shift in the medical, political and social position of tonsillectomy rested upon several factors: changes in the organisation of medical institutions and national health care; changes in medical technologies and the criteria by which they are judged; the political, cultural and economic context of Britain; and the social role of the patient. Tonsillectomy was not a mere passive subject of external influences, but became a potent concept in medical, political, and social discourse. Therefore, it reciprocally influenced these discourses and subsequently the development of twentieth-century British medicine. These complex interactions between ‘medical’ and ‘non-medical’ spheres question the possibility of demarcating what is internal from what is external to medicine.

Keywords: Tonsillectomy, Surgery, Activism, Clinical Trials, Childhood, Technology

Introduction

In 1927, a procedure condemned by one *Daily Express* journalist as a ‘wicked operation’ was performed on over 80 000 British schoolchildren.¹ This operation was tonsillectomy, the surgical removal of the tonsils, which for several decades was the most common reason for a child to be in hospital. Although tonsillectomy has been considered ‘relatively

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¹ ‘Tonsil Removal Dangers’, *Daily Express*, 11 August (1927), 6; Alison J. Glover, ‘The Incidence of Tonsillectomy in School Children’, *International Journal of Epidemiology*, 37 (2008), 11.

stable and widespread over time',² throughout much of the twentieth century it occupied a controversial position. By the end of the 1970s opinion turned against tonsillectomy; then widely considered a 'dangerous fad' in professional, public and political circles. Much research has gone into the dynamics by which surgical techniques gain momentum and become accepted, including the social, political and economic conditions of success, as well as work by patients and doctors, and clinical trials of new innovations.³ These factors change what a technique means in a historical context, contributing to acceptance or rejection. By disentangling these threads, this article will account for the profound cultural shift across the twentieth century in attitudes towards tonsillectomy, an old technique with complex and evolving meanings.

Histories of surgery in this period have focused on 'surgical firsts': cutting-edge procedures that elicit widespread attention.⁴ For example, Ayesha Nathoo's *Hearts Exposed* provides fascinating analysis of the media coverage of the first heart transplant.⁵ Tonsillectomy, seemingly mundane and 'successful', has largely escaped historical attention.⁶ However, the routine nature of tonsillectomy makes it an invaluable lens through which to examine more closely how changes in medical thought and practice were framed by evolving attitudes towards childhood,⁷ by the impact of the consumer movement in the late 1960s,⁸ by modern reformism and conservatism in surgery,⁹ and by the role of clinical trials in technique success.¹⁰

Most historical literature on tonsillectomy has been composed by clinicians. They have traced trends in surgical technique from 'cold steel' blunt dissection to 'modern' electrocautery and coblation (controlled ablation using radio waves),¹¹ and have observed the evolution of techniques to reduce post-operative haemorrhage.¹² These narratives position tonsillectomy centrally in discussions of innovation and the dynamics of technology change in surgery and medicine.¹³ Harry Collins and Trevor Pinch have used the operation as a valuable case study in the sociology of medicine to emphasise the inherent uncertainty in tonsillectomy recommendation – and all medical diagnosis.¹⁴ Scholarship on the

² Thomas Schlich and Christopher Crenner, 'Technological change in surgery: an introductory essay', in T. Schlich and C. Crenner (eds), *Technological Change in Modern Surgery: Historical Perspectives on Innovation* (Rochester, NY: The University of Rochester Press, 2017), 6.

³ *Ibid.*, 1–20.

⁴ Christopher Lawrence and Tom Treasure, 'Surgeons', in R. Cooter and J. Pickstone (eds), *Companion Encyclopedia of Medicine in the Twentieth Century* (Hoboken, NJ: Routledge, 2013), 666.

⁵ Ayesha Nathoo, *Hearts Exposed: Transplants and the Media in 1960s Britain* (Basingstoke: Palgrave Macmillan, 2009), 1–4.

⁶ Schlich and Crenner, *op. cit.* (note 2), 6.

⁷ Matthew Thomson, *Lost Freedom: The Landscape of the Child and the British Post-War Settlement* (Oxford: Oxford University Press, 2013), 1–20.

⁸ Alex Mold, 'Repositioning the Patient: Patient Organizations, Consumerism, and Autonomy in Britain during the 1960s and 1970s', *Bulletin of the History of Medicine*, 87, 2 (2013), 225–49.

⁹ Roger Kneebone and Sally Frampton, 'John Wickham's New Surgery: 'Minimally Invasive Therapy', Innovation, and Approaches to Medical Practice in Twentieth-century Britain', *Social History of Medicine*, 30, 3 (2016), 544–66.

¹⁰ David S. Jones, 'Visions of a Cure: Visualization, Clinical Trials, and Controversies in Cardiac Therapeutics, 1968–98', *Isis*, 91 (2000), 504–41.

¹¹ Napoleon Charaklias, 'Constantinos Mamais and B. Nirmal Kumar, 'The Art of Tonsillectomy: The UK Experience for the Past 100 Years'', *Otolaryngology – Head and Neck Surgery*, 144, 6 (2011), 851–4.

¹² L. McClelland and N.S. Jones, 'Tonsillectomy: Haemorrhaging Ideas', *Journal of Laryngology and Otology*, 119, 10 (2005), 753–8.

¹³ Schlich and Crenner, *op. cit.* (note 2), 1–20.

¹⁴ Harry Collins and Trevor Pinch, 'Tonsils: diagnosing and dealing with uncertainty', in *Dr. Golem: How To Think About Medicine* (Chicago, IL, and London: University of Chicago Press, 2005), 80–3.

experience of tonsillectomy in the twentieth-century United States (US) has shown that debates about tonsillectomy were also debates about the nature of evidence, the salience of clinical experience, and the roles of competing medical specialities.¹⁵ These themes are prominent in British discourse, but this article goes further by establishing the significance of patient and parent voices, the role of the press and the politics of tonsillectomy.

Tonsillectomy is exceptional in its almost exclusive performance on children. This is important as child health has been a measure of success in Western health care systems for over a century.¹⁶ Although historical interest has focused on child psychiatry, researchers are coming to utilise the child's experience in diverse histories of medicine.¹⁷ The history of tonsillectomy allows us to examine how perceptions of childhood have influenced dramatic changes in the paediatric medical encounter, and in broader health care provision, since the nineteenth century.¹⁸

This article focuses on tonsillectomy in post-war Britain, but begins in about 1900. Health care provision before the formation of the National Health Service (NHS, 1948) was conducive to rising tonsillectomy rates into the middle of the century. Increased state intervention in health care created and stabilised structural incentives for doctors to perform the operation. Disciplinary divisions between general practitioners (GPs), otorhinolaryngologists (now more commonly known in the UK as ear, nose and throat, or ENT, surgeons), and other specialists shaped the routinisation of the operation. They also shaped contemporary debate about the 'correct' method of tonsil removal: complete or partial. In the 1940s and 1950s, poliomyelitis became an increasing public health concern, and a speculated link between tonsillectomy and bulbar poliomyelitis (a variant that effects the brainstem) energised the tonsillectomy debate. This dispute was exacerbated by a tension between clinicians and researchers who found epidemiological evidence convincing, and surgeons who favoured their own experiential learning. The poliomyelitis controversy created a precedent for more extensive criticism of this operation, and medicine broadly. In reaction, during the early 1960s medical reformers sought to standardise and 'rationalise' tonsillectomy. Reformers were opposed by elite surgeons who preferred to maintain long-standing surgical traditions. Towards the end of the decade, tonsillectomy breached the boundaries of professional discourse and began to be considered within new frameworks. By the end of the 1960s, enough political importance had accumulated to justify the intensification of state-funded attempts to finally solve the tonsillectomy debate. These attempts involved much work, and were met with many challenges.

Historic actors referred to controversies about tonsillectomy as the 'tonsil problem', a nebulous term encompassing numerous aspects of dispute over the operation. This article will account for the changes in opinion towards the tonsil problem, and within the problem itself. It will demonstrate that the tonsil problem was shaped by disciplinary interests, health care structures, the political context and the patient's (or the patient's parents') attitudes. The tonsil problem reciprocally shaped political debate, disciplinary

¹⁵ Gerald N. Grob, 'The Rise and Decline of Tonsillectomy in Twentieth-Century America', *Journal of the History of Medicine and Allied Sciences*, 62, 4 (2007), 383–4.

¹⁶ Joseph P. Byrne (ed.), *Encyclopedia of Pestilence, Pandemics, and Plagues* (Westport, CT, and London: Greenwood Press, 2008), 85.

¹⁷ Emm Barnes, 'Between Remission and Cure: Patients, Practitioners and the Transformation of Leukaemia in the Late Twentieth Century', *Chronic Illness*, 3, 4 (2007), 253–64.

¹⁸ Jonathon Gillis, 'The History of the Patient History since 1850', *Bulletin of the History of Medicine*, 80, 3 (2006), 490–512.

values, public perceptions of medicine and how health care was pragmatically provided. As well as being an illustrative case study, tonsillectomy has played an important role in the development of twentieth-century British medicine.

‘Cold Steel’ and Hot Tempers: Tonsillectomy and Health Care Provision before the Second World War

Although the establishment of the NHS was a watershed for many aspects of health care provision, for tonsillectomy it cemented pre-existing structures that facilitated and incentivised the operation. Two main political factors contributed. First, the School Medical Service (established 1908) compelled local education authorities to provide medical inspection for schoolchildren. This brought children of all socio-economic classes under medical surveillance, so a greater number could be identified with tonsil disease. Secondly, the 1911 National Health Insurance (NHI) Act extended support previously provided by ‘friendly societies’ through financial relief and medical access during sickness.¹⁹ By the 1940s the NHI scheme covered more than half of the population, allowing less affluent families to afford medical care for children. These policies allowed more cases of apparently diseased tonsils to be identified, more children to be referred for surgery from school, general practice or directly, and allowed more families to afford tonsillectomy. As payment per service was common into the 1940s, there was a financial incentive for doctors to operate.²⁰

Meanwhile, a division between primary and secondary health care developed. From 1929 local hospitals supplemented their voluntary counterparts, allowing larger numbers of people to access them.²¹ Surgery was becoming increasingly technologically stringent, which encouraged relocation from home to hospital and secured tonsillectomy in the domain of the specialist surgeons. This facilitated development of new disciplines,²² and otorhinolaryngology (ENT) developed from surgical otology and laryngology – a subdivision of respiratory medicine. The new ENT specialty was consolidated through societies, journals and specialist hospitals.²³ Due to the liminal position of the tonsils between the throat and middle ear, tonsillectomy anatomically linked, and thus justified, a discipline formed from otherwise disparate origins. It was largely safe, and so quick that boasts of operative speed were common in medical journals.²⁴ Pre-war health care provision in Britain produced ideological and financial incentives for practitioners to recommend and perform an ‘easy’ operation, and some surgeons accumulated large fortunes.²⁵ These factors explain both the long-standing commitment to tonsillectomy from ENT surgeons and the rising rates of tonsillectomy in the first half of the century.

Structural incentives to perform tonsillectomy were supplemented and facilitated by a national concern for the eligibility of young adults for labour and military service. The

¹⁹ Charles Webster, *The National Health Service: A Political History* (Oxford: Oxford University Press, 2002), 2, 5.

²⁰ Audrey Leathard, *Health Care Provision: Past, Present and into the 21st Century* (Cheltenham: Stanley Thornes, 2000), 3–4.

²¹ Webster, *op. cit.* (note 19), 5.

²² Leathard, *op. cit.* (note 20), 3.

²³ S. Yalamanchili, ‘Why Should Disorders of the Ear, Nose and Throat Be Treated by the Same Specialty? Can This Situation Persist?’, *The Journal of Laryngology & Otology*, 123, 4 (2004), 368.

²⁴ George E. Waugh, ‘A Simple Operation for the Total Removal of Tonsils, with Notes on 900 Cases’, *The Lancet*, 173, 4471 (1909), 1315.

²⁵ Royal College of Surgeons of England, ‘Waugh, George Ernest’, *Plarr’s Lives of the Fellows Online* (2013).

government was alarmed by the poor condition of volunteers for the Boer War (1899–1902), and these anxieties were reinforced by a 1904 Interdepartmental Committee on Physical Deterioration.²⁶ An influential 'focal theory' suggested that infected bodily sites acted as sources from which contamination spread around the body.²⁷ Elite surgeons like the Cambridge graduate George Ernest Waugh used this theory to present tonsillectomy as a technological solution to apparent social deterioration.²⁸ The theory allowed disparate disorders including physical and mental underdevelopment to be attributed to infected tonsils.²⁹ Tonsils were considered by Waugh and others to be particularly potent foci: infected material could be swallowed *and* spread to nearby glands.³⁰ The greatest cause of death in adolescence at the start of the century, tuberculosis, was thought to spread in this manner, creating a culturally significant reason to perform tonsillectomy.³¹ However, the operation could also be authorised for trivial conditions, like bad breath.³² To some elite surgeons, 'compulsory' 'universal' tonsillectomy was the logical conclusion to tonsil disease as it was so common and prevention was preferred to cure.³³ These surgeons combined a public concern for the care of children as future citizens with a modernist tendency for technological solutions to socio-medical problems.³⁴ They elevated tonsillectomy to a position of national political and moral importance.³⁵ This both justified their recommendation of the operation, and encouraged parents to authorise it.

Despite structural, medical and socio-ideological encouragement to perform tonsillectomy, young surgeons with smaller private practices resisted it. Such opponents often blamed the misinformed 'laity' who supposedly requested the operation for their children and the enthusiastic surgeons who found it easier to acquiesce than refuse if tonsillectomy was unnecessary.³⁶ Turning parents into scapegoats was logical when they could not defend themselves in professional discourse and contemporary medical textbooks likened a parent or patient to a 'difficult witness'.³⁷ Opponents also argued that the function of the tonsils was unknown, and that they were just as likely to be protective as causative of disease.³⁸ One surgeon likened this to military defence, suggesting that tonsils were to health what Gibraltar was to British security in the Mediterranean.³⁹

²⁶ Leathard, *op. cit.* (note 20), 2.

²⁷ Grob, *op. cit.* (note 15), 387–9; 'West London Medico-Chirurgical Society', *The Lancet*, 181, 4686 (1913), 1737.

²⁸ Royal College of Surgeons of England, *op. cit.* (note 25).

²⁹ Waugh, *op. cit.* (note 24), 1314; J.W. Carr, 'Annual Oration: On Life and Problems in a Medical Utopia', *The Lancet*, 201, 5203 (1923), 996.

³⁰ Waugh, *op. cit.* (note 24), 1314.

³¹ 'The British Medical Association: Seventy-Eighth Annual Meeting in London', *The Lancet*, 176, 4541 (1910), 814; Linda Bryder, *Below The Magic Mountain: A Social History of Tuberculosis in Twentieth-Century Britain* (Oxford: Clarendon, 1988), 1.

³² 'West London', *op. cit.* (note 27), 1737.

³³ Carr, *op. cit.* (note 29), 996.

³⁴ Janet Golden and Russel Viner, 'Children's experience of illness', in R. Cooter and J. Pickstone (eds), *Companion Encyclopedia of Medicine in the Twentieth Century* (Hoboken, NJ: Routledge, 2013), 575; Lawrence and Treasure, *op. cit.* (note 4), 654.

³⁵ Carr, *op. cit.* (note 29), 1001.

³⁶ 'Removal of the Tonsils', *The Lancet*, 179, 4635 (1912), 1773; Lawrie H. McGavin, 'A Note On Tonsillar Enlargements and their Treatment', *The Lancet*, 162, 4178 (1903), 876.

³⁷ Gillis, *op. cit.* (note 18), 502.

³⁸ McGavin, *op. cit.* (note 36), 876–7.

³⁹ 'West London', *op. cit.* (note 27), 1737.

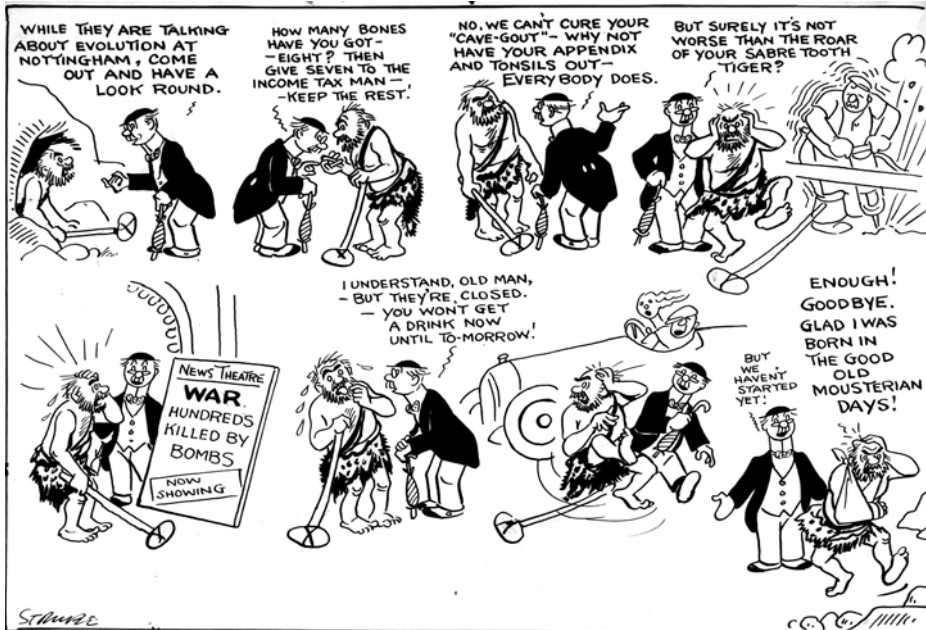


Figure 1: Sidney 'George' Strube, 'Man and Evolution' or 'Benefits of Civilisation', *Daily Express*. Image courtesy of N&S Syndication, British Cartoon Archive, University of Kent: GS0465 (3 September 1937).

Criticisms of tonsillectomy in the national press were usually intrinsic to wider complaints about modern society. A 1937 *Daily Express* cartoon depicted a caveman transported to interwar Britain (figure 1). He was told 'Why not have your appendix and tonsils out – everybody does', before deciding he preferred prehistoric times.⁴⁰ This cartoon demonstrates both the ubiquity of tonsillectomy by the late 1930s, and how the operation became a symbol of the problems associated with a modern, medicalised society.

Surgeons preferred to debate the technique of surgery. 'Tonsillectomy' entailed complete removal of the tonsil, while 'tonsillotomy' described partial removal of tonsillar tissue.⁴¹ A more conservative operation, tonsillotomy was often preferred by provincial practitioners – for example in the Indian Medical Service – as it was half as likely to cause post-operative haemorrhage.⁴² Conversely a method of blunt tonsillectomy devised by Waugh was popular in the first decades of the century, especially among elite London medical societies,⁴³ as it was 'clean, complete and radical'.⁴⁴ Tonsillectomy emerged as the preferred technique for several decades as its supporters occupied influential social positions, and the focal theory encouraged decisive interventions. Tonsillectomy was so dominant that one practitioner received 'loud cries of disapproval' when he announced to the Royal Society of Medicine that he had performed a tonsillotomy on his own child.⁴⁵

⁴⁰ Sidney 'George' Strube, 'Man and Evolution' or 'Benefits of Civilisation', *Daily Express*, British Cartoon Archive, University of Kent: GS0465 (3 September 1937).

⁴¹ Frederick Pybus, 'Eneucleation v. Tonsillotomy', *The Lancet*, 180, 4647 (1912), 850.

⁴² Harold Whale, 'The Remote Results of Tonsillotomy and Tonsillectomy: An Analytical Scrutiny of 220 Unselected Cases', *The Lancet*, 181, 4668 (1913), 446.

⁴³ Waugh, *op. cit.* (note 24), 1314–15; Pybus, *op. cit.* (note 41), 850; 'West London', *op. cit.* (note 27), 1738.

⁴⁴ 'The British Medical Association', *op. cit.* (note 31), 814.

⁴⁵ H.V. Forster, 'Poliomyelitis and Tonsillectomy', *The Lancet*, 266, 6894 (1955), 824–5.

Heterogeneity of viewpoints regarding the tonsil problem in pre-war and interwar Britain reflected the fragmented state of health care, and developing professional divisions. Established surgeons had personal, financial and institutional interests in propagating the performance of tonsillectomy, supported by health care structures. They presented tonsillectomy as a modernist solution to social problems, in contrast to political commentators who saw it as a symptom of the problems of modern society. Practitioners less invested in the operation advocated restraint – or tonsillotomy – with little success. Grob and Collins and Pinch have emphasised the ideological importance of focal theory in the rise of tonsillectomy. However, I argue that financial and structural incentives in a politico-cultural context that valued both technological interventions and the health and development of children contributed more significantly to the entrenchment of tonsillectomy in both medicine and society.⁴⁶

A specific case can highlight how entrenched the operation was in British culture. On 1 May 1936, at 9.50 am, a 3-year-old child named Guillian Colwell underwent tonsillectomy in a Brighton hospital.⁴⁷ The operation had been recommended for a 'cold and temperature'. Although it was a routine case performed by an 'acknowledged expert',⁴⁸ the previously healthy Colwell was dead before ten o'clock due to anaesthetic 'misadventure'.⁴⁹

The death of a child under routine circumstances was troubling enough to warrant an inquest, but neither the coroner, the surgeon, the anaesthetist nor even the father questioned the wisdom of undertaking the operation. Tonsillectomy was so ubiquitous that it went unchallenged: if a surgeon suggested tonsillectomy was 'necessary', any adverse outcomes were consigned as 'misadventures', sequelae of pathological processes rather than the intervention that precipitated them. Tonsillectomy was rendered invisible and thus unassailable. In 1938, an American doctor suggested that since 1900, tonsillectomy had become so commonplace that it was sometimes actively sought by parents.⁵⁰ Colwell's unfortunate story shows that this change also occurred in Britain. The operation had become a medical ritual that twentieth-century children passed through to access a 'normal' childhood while any accidents incurred were accepted without question.⁵¹

'Three Open Wounds': Fear and Folly of Tonsillectomy in the Polio Years (1942–55)

The rising cultural significance of poliomyelitis towards the middle of the twentieth century profoundly influenced tonsillectomy debates – as it did public health and biomedical science. For decades poliomyelitis caused 'terror for parents' by causing seasonal gastro-intestinal epidemics with occasional severe neurological sequelae.⁵² During the 1940s and 1950s preoccupation crystallised as children became sentimentalised

⁴⁶ Collins and Pinch, *op. cit.* (note 14), 66; Grob, *op. cit.* (note 15), 383, 387–90.

⁴⁷ Crow, 'Circumstances of the Death under Anaesthetic of Guillian Colwell', East Sussex Record Office, COR 3/2/1936/31 (1 May 1936); Charles Webb, 'Inquisition on an Inquest held wholly without a Jury, taken on View of the Body of Guillian William Colwell', East Sussex Record Office, COR 3/2/1936/31 (4 May 1936).

⁴⁸ Charles Webb, 'The Informations of Witnesses', East Sussex Record Office, COR 3/2/1936/31 (4 May 1936).

⁴⁹ M.A. Leslie-Smith, 'Notes of the Post-Mortem Examination', East Sussex Record Office, COR 3/2/1936/31 (2 May 1936); William Halliden, 'Re Death of Guillian William Colwell, aged 3 years', East Sussex Record Office, COR 3/2/1936/31 (1 May 1936); Webb, *op. cit.* (note 47).

⁵⁰ William N. Macartney, *Fifty Years a Country Doctor* (New York: Dutton, 1938), 533–4.

⁵¹ Golden and Viner, *op. cit.* (note 34), 583.

⁵² Byrne, *op. cit.* (note 16), 547, 86.

as individuals,⁵³ and compassion for their welfare converged with military significance during the Second World War and the possibility of a modern medical cure.⁵⁴ As poliomyelitis had a greater cultural impact in the US, American discourse linking it to tonsillectomy began earlier than in Britain, and finished earlier following mass vaccination.⁵⁵ During the British debates, actors could draw upon existing American literature for evidence.

In the US, debate was mostly between paediatricians, who believed tonsillectomy was hazardous, and laryngologists who argued it was safe and could not be postponed.⁵⁶ Similar disciplinary divisions existed in British debates, though they were still more complex and subtle. Broadly, ENT specialists maintained support for the operation, while other medical specialities and researchers advocated more caution. Protagonists negotiated their stances using epidemiological findings, personal experience and medico-scientific arguments.

American quantitative evidence was found compelling by British epidemiologists, who were convinced of a link between tonsillectomy and bulbar poliomyelitis by the 1940s.⁵⁷ The large statistical studies and case reports seemed to make it ‘inescapable’ that tonsillectomy ‘precipitated’ poliomyelitis.⁵⁸ Elite ENT surgeons – ‘leaders’ of otorhinolaryngology – did not share this belief and instead relied on surgical experience and the logic that removing diseased tonsils preceded a child’s recovery. These surgeons were convinced of the value of the operation, and argued that there might be a correlation between tonsillectomy and poliomyelitis, but that there was no causative link.⁵⁹

Some established surgeons used the link to poliomyelitis to support their nostalgic imagination of surgery before the First World War. They believed recent attempts to optimise surgery had made it more technologically stringent, but also made patients more vulnerable to infectious disease.⁶⁰ Supposedly, it was not tonsil surgery that caused poliomyelitis, but modern tonsillectomy, and a return to ‘old fashioned’ tonsillotomy would remove any relationship. They supported this by suggesting that the tonsils acted as ‘filter and buffer’ to protect against neurological damage. A correlation with poliomyelitis threatened the medical value of tonsil removal, so proponents of tonsillectomy and tonsillotomy used empirical, ideological and medical arguments to support its practice in a specific, seemingly safer, manner.

One otorhinolaryngologist who stalwartly *opposed* tonsillectomy was T.B. ‘Tubby’ Layton. A surgeon at Guy’s Hospital, he published against tonsillectomy from 1914,⁶¹ and described it with ‘voluble language’.⁶² Layton denounced tonsillectomy not because of ‘absolute’ proof it caused poliomyelitis (as epidemiologists believed), but because his personal experience dictated that operating on children during epidemics caused more harm than benefit. Layton presented this as an idiom – ‘the principle of the dominating

⁵³ Golden and Viner, *op. cit.* (note 34), 581.

⁵⁴ John R. Paul, *A History of Poliomyelitis* (New Haven, CT, and London: Yale University Press, 1971), xiii.

⁵⁵ Grob, *op. cit.* (note 15), 402–4.

⁵⁶ *Ibid.*, 402–4.

⁵⁷ T.B. Layton, ‘Poliomyelitis Following Tonsillectomy’, *The Lancet*, 254, 6575 (1949), 433.

⁵⁸ ‘Poliomyelitis After Tonsillectomy’, *The Lancet*, 240, 6219 (1942), 552.

⁵⁹ Layton, *op. cit.* (note 57), 433; see also Jones, *op. cit.* (note 10), 504–5.

⁶⁰ James Melvin, ‘Poliomyelitis and Tonsillectomy’, *The Lancet*, 266, 6893 (1955), 773.

⁶¹ T.B. Layton, ‘Tonsils and Adenoids in Children: A Plea for Fewer Operations’, *The Lancet*, 183, 4729 (1914), 1106–8.

⁶² ‘In Memoriam: T.B. Layton’, *Annals of The Royal College of Surgeons of England*, 34, 3 (1964), 205.

lesion' – to reframe good 'clinical judgement' as conservatism regarding the operation. He argued that all tonsillectomies during poliomyelitis epidemics should be cancelled. Although doctors held power in the medical encounter, Layton believed parents were 'in the end... responsible' and could refuse tonsillectomy if they knew the risks.⁶³

Christopher Lawrence has noted the popularity of 'holist' sentiments among elite interwar British clinicians. Layton was probably exposed to these perspectives during his long career, and fitted the category by emphasising clinical experience and rejecting medical reductionism. Therefore, he opposed tonsillectomy as a procedure that excessively emphasised local pathology, especially in a wider context of epidemic disease. Lawrence suggests that holist sentiments extended beyond medicine, and Layton drew on non-medical resources to solve the tonsil problem such as the influence of administrators and parents.⁶⁴ Layton exploited the potential link between tonsillectomy and poliomyelitis within a holist world-view to persuade others that the operation was ill-advised.

Some academic surgeons also opposed tonsillectomy by building on earlier suggestions that the tonsils were protective against infectious diseases like poliomyelitis. They emphasised the immunological compromise created by 'three open wounds' and believed the tonsils conferred 'immunity' against such diseases,⁶⁵ as part of a circle of lymphoid tissue in the throat known as 'Waldeyer's ring'.⁶⁶ Logically, it would follow that tonsillectomy could cause both a short-term risk and long-term predisposition to infectious diseases. A retrospective study of the 1947–8 South Australian poliomyelitis epidemic vindicated these predictions. In over half of bulbar poliomyelitis cases, the individual had received tonsillectomy at least five years prior, supporting an increasingly popular theory: that susceptibility persisted after wounds healed.⁶⁷ Immunological and epidemiological arguments converged and provided mutual reinforcement. It was not enough to defer surgery until next year: tonsillectomy would require large-scale reduction.

Poliomyelitis epidemics altered the cultural context to favour opponents of tonsillectomy. The 1948–9 report of the Chief Medical Officer to the Ministry of Education counted 96 262 tonsillectomies in 1948, compared to 69 449 in 1949. The report suggested the large number in 1948 was due to deferred operations, following an epidemic in 1947.⁶⁸ That year, the Ministry of Health (MoH) issued a memorandum advising doctors not to operate during poliomyelitis epidemics: tonsillectomy was rarely an emergency so could and should be postponed.⁶⁹ The report both demonstrated and contributed to a large-scale shift in opinion and practice regarding tonsillectomy. From the 1940s, the Medical Research Council (MRC) investigated tonsillectomy. The potential link between intervention and disease possessed sufficient cultural potency to gain the attention of state

⁶³ Layton, *op. cit.* (note 57), 433.

⁶⁴ Christopher Lawrence, 'Still incommunicable: clinical holists and medical knowledge in interwar Britain', in C. Lawrence and G. Weisz (eds), *Greater than the Parts: Holism in Biomedicine, 1920–50* (New York and Oxford: Oxford University Press, 1998), 94, 107.

⁶⁵ Kenelm H. Digby, 'Poliomyelitis and Tonsillectomy', *The Lancet*, 254, 6578 (1949), 580.

⁶⁶ W. von Waldeyer-Hartz, 'Ueber den lymphatischen Apparat des Pharynx', *Deutsche Medizinische Wochenschrift*, 10 (1884), 313.

⁶⁷ Melvin, *op. cit.* (note 60), 773; 'Poliomyelitis and Tonsillectomy', *The Lancet*, 262, 6792 (1953), 925–6.

⁶⁸ 'Children Never So Healthy: But Serious Loss of School Dentists', *The Manchester Guardian*, 17 January (1952), 8.

⁶⁹ 'Report of the Ministry of Health for the Year Ended 31st March, 1949 Including the Report of the Chief Medical Officer on the State of the Public Health for the Year Ended 31st December, 1948', Cmd. 7910 (London: HMSO, 1950), 6.

bodies and motivate them to limit operations – in 1955 the MRC joined the MoH in reporting that tonsillectomy caused a persistent risk of poliomyelitis infection.⁷⁰

The connection to poliomyelitis energised the tonsil problem by injecting an emotional and moral importance to medical discourse. Old arguments were reiterated and reworked within a new framework, alongside the formulation and elaboration of new arguments. Discussions combined epidemiological, medical, empirical and immunological evidence. Assertions were negotiated to facilitate the institutional and personal interests and values of participants. Collins and Pinch have suggested that ‘routine uncertainty and routine death are routinely ignored’.⁷¹ Poliomyelitis was an exceptional disease, which by association allowed tonsillectomy to be exceptionally scrutinised. It acted as a lens through which medical professionals re-examined their own actions, cultivating heightened self-awareness and changes in thought and practice over the next decade.

The ‘Quick’ and the Careful: Tonsillectomy and Reform in the Early 1960s

The increasing visibility of tonsillectomy in 1960s Britain forced doctors and health administrators to reconsider their stances on the operation. Simultaneously, perceived shortcomings of the NHS instigated attempts to rationalise and unify health care services.⁷² Reformers from various disciplines responded by emphasising the uncertainty about tonsillectomy and advocating change in medical practice. Such scrutiny of tonsillectomy reconstructed the operation as an increasingly political matter. Elite surgeons resisted these changes by arguing that the problem lay not with the operation, but with the practitioner.

Sir Denis Browne was a prominent surgeon-reformer, described as the ‘father of paediatric surgery in Britain’ after four decades at Great Ormond Street Hospital. Browne’s notorious perfectionism entered the tonsillectomy debate as he criticised surgery that did not meet his ‘requisites’.⁷³ These surgical guidelines emphasised slow, methodical techniques to attempt to prevent ‘inevitable deaths’.⁷⁴ From the 1950s, some surgeons became more self-aware of surgical hazards,⁷⁵ but Browne complained that others were succumbing to professional bravado which led them to aim for ‘quick’ or ‘slick’ operations. Browne saw that rates of post-operative haemorrhage were higher in tonsillectomy than other operations, and suggested this was only accepted because the operation was ubiquitous.⁷⁶ Surgical tradition could not justify the psychological repercussions: the ‘sickening anxiety’ experienced by the ‘scared and exsanguinated’ child. Browne feared an ‘uncomfortable’ external inquiry, so advocated a ‘central authority’ of surgeons to demonstrate they deserved autonomy by regulating practice.⁷⁷ He called for self-reflection at both the individual and professional level to protect medical practice from external control, and children from superfluous harm.

Practitioners of other specialities also advocated reform regarding the tonsil problem. Paediatricians drew attention to the variability of tonsillectomy rates between

⁷⁰ ‘Poliomyelitis and Tonsillectomy: A Report of the Medical Research Council Committee on Inoculation Procedures and Neurological Lesions’, *The Lancet*, 266, 6879 (1955), 5–10.

⁷¹ Collins and Pinch, *op. cit.* (note 14), 83.

⁷² Charles Webster, ‘Medicine and the Welfare State 1930–70’, in R. Cooter and J. Pickstone (eds), *Companion Encyclopedia of Medicine in the Twentieth Century* (Hoboken, NJ: Routledge, 2013), 135.

⁷³ Peter M. Dunn, ‘Sir Denis Browne’, *West of England Medical Journal*, 112, 4 (2013), 1.

⁷⁴ Denis Browne, ‘Deaths From Tonsillectomy’, *The Lancet*, 282, 7322 (1963), 1377.

⁷⁵ Kneebone and Frampton, *op. cit.* (note 9), 550.

⁷⁶ Denis Browne, ‘Deaths From Tonsillectomy’, *The Lancet*, 283, 7331 (1964), 496.

⁷⁷ Browne, *op. cit.* (note 74), 1377.

socio-economic classes. Children of 'black coated' middle-class professionals were more likely to undergo tonsillectomy, and paediatricians condemned this seemingly illogical trend. They experienced the 'striking list' of sequelae tonsillectomy caused, and thus portrayed 'irrational' operations as morally reprehensible. Instead, paediatricians advocated introducing guidelines for recommending the operation. They sought to account for medical costs and benefits in individual patients, just as rational accounting was sought in the *structure* of the NHS.⁷⁸

Anaesthetists also advocated medical reform, arguing that tonsillectomy was less safe than 'commonly supposed'. They took partial responsibility for over-prescribing the opiate anaesthetic 'nepenthe', which was considered 'disappointingly ineffective' and dangerous – potentially causing death through respiratory depression. This was combined with simple patient care, as a tendency to sit children up in bed could hide any bleeding in the throat and compound nepenthe over-prescription.⁷⁹ Reformers attempted to improve tonsillectomy safety and efficiency by altering both technical and everyday hospital practice. Reducing deaths specifically associated with their discipline, as well as with general medical practice, could alleviate the risk of losing social standing or autonomy for the profession.

Such reformers were opposed by elite surgeons who believed their operative skill was sufficient to elevate tonsillectomy. They believed skilful, well-practised surgeons could make the operation quick and safe, and that complications were caused by incompetence rather than inherent in the operation.⁸⁰ By exclaiming 'It's not what you do – but the way that you do it!', these surgeons reframed the tonsil problem from whether the operation should be performed, to who was able to perform it.⁸¹ Predictably, the elite surgeons were to be exemplars. Health administrators extended this argument to medical facilities. After a child died following tonsillectomy in a Welsh cottage hospital in 1960, the hospital was found to be lacking in technical facilities and was closed.⁸² Tonsillectomy had become a benchmark of adequacy: whether of surgical skill or technological facilities.

From the 1960s, the tonsil problem was increasingly scrutinised by non-professionals, as articles in the national press dealing with tonsillectomy became more frequent. In some cases, they re-presented articles from medical publications to a lay audience which questioned medical efficacy or cited epidemiological studies.⁸³ This contributed to a growing public critique of both tonsillectomy and the medical profession. Conversely, other articles suggested that the tonsil problem had been solved. A 1962 *Observer* article argued that society had moved out of the 'age of dangerous surgery' and into the 'age of dangerous medicine', as doctors tended to avoid tonsillectomy unless 'absolutely essential'.⁸⁴ This ignored the heterogeneity of opinion within and without the medical profession regarding the value of the operation and what was considered 'essential'. Despite a presumptuous conclusion, the article was demonstrative of public wariness of medical practice, whether it was pharmaceutical drugs or surgical interventions that were perceived as 'dangerous'.

⁷⁸ '“Odd Findings” in Tonsils Cases', *The Times*, 1 December (1962), 6.

⁷⁹ Norman Tate, 'Deaths From Tonsillectomy', *The Lancet*, 282, 7317 (1963), 1090–1.

⁸⁰ R.A.R. Wallace, 'Deaths From Tonsillectomy', *The Lancet*, 283, 7327 (1964), 270; J.S. Martin, 'Deaths From Tonsillectomy', *The Lancet*, 283, 7325 (1964), 166.

⁸¹ Wallace, *ibid.*, 270.

⁸² 'Cottage Hospital Closed', *The Times*, 16 July (1960), 6.

⁸³ '“Odd Findings”', *op. cit.* (note 78), 6; Abraham Marcus, 'Taking Out Tonsils', *The Observer*, 4 June (1961), 33.

⁸⁴ '“Age of Dangerous Medicine” Warning', *The Observer*, 29 July (1962), 3.

State agencies also increased their scrutiny of the operation throughout the 1960s, as the tonsil problem became political. The 1958–9 report by the Chief Medical Officer to the Ministry of Education noted ‘striking contrasts’ between tonsillectomy rates for different areas, and emphasised the high proportion of British children undergoing tonsillectomy: twenty per cent by age fourteen. However, it did not explain these differences beyond superficial attributions to class or location.⁸⁵ The tonsil problem also entered the House of Commons. In 1961, new Parliamentary Secretary for Science, Denzil Freeth, received his first questions, containing challenges to the ‘value’ of 200 000 tonsillectomies occurring that year.⁸⁶ However, state agencies appeared more curious than concerned about the operation, and there was no major political impetus to investigate tonsillectomy.

By the 1950s, ‘medical corporatism’ had arisen in British health care in response to social, economic and political pressures. Attempts to improve the administrative efficiency of state-provided health care encouraged the adoption of methods of scientific management.⁸⁷ As tonsillectomy was repositioned as an irrational procedure, it became subject to these methods. Clinician-reformers suggested changes in the practice of tonsillectomy and medicine generally to avoid attacks on the profession, while politicians attempted to improve efficiency for economic and political purposes. However, as well as being an object of rationalisation, tonsillectomy was also a measure of the efficacy of a hospital or individual.⁸⁸ The tonsil problem could not be resolved solely within disciplinary boundaries, and over the rest of the 1960s, tonsillectomy would become scrutinised by a broader audience, driving calls for a cohesive solution.

‘Medicine... under the Microscope’: Inspecting Tonsillectomy in the Late 1960s

In the late 1960s, tonsillectomy became more visible and criticised. Some of the strongest complaints came from the National Association for the Welfare of Children in Hospital (NAWCH), founded in 1962 as Mother Care for Children in Hospital. NAWCH lobbied for unrestricted visiting of children in hospital, believing that separation from mothers could harm children. According to Judith Pead, NAWCH’s chair, hospital wards contained ‘sights and sounds’ that could cause psychological trauma. Furthermore, Pead specifically opposed tonsillectomy, coining the term ‘tonsil children’ to emphasise the loss of an organ and the medicalisation of childhood that the operation encouraged.⁸⁹ NAWCH used the national press alongside ‘subtle but persistent’ tactics such as the distribution of leaflets and folding beds to hospitals. Through the 1960s NAWCH became more influential, with 50 branches and 3000 members by 1969.⁹⁰

In a survey of hospital visiting hours, NAWCH found that children undergoing tonsillectomy were especially restricted. Visiting was limited by 19 out of 26 hospitals on the day of operation, and a similar number prevented it throughout the stay. This contradicted a 1965 proclamation by the Minister of Health that 79% of hospitals allowed *unrestricted* visiting. NAWCH found this discrepancy especially worrying due

⁸⁵ Alfred Byrne, ‘Vehicles as Great a Menace as Disease’, *The Guardian*, 13 January (1961), 5.

⁸⁶ ‘Tonsillectomy and Stags: Fleet Street, Sunday Night’, *The Guardian*, 15 May (1961), 8; ‘Commons Sitting of Tuesday, 16th May, 1961’, 640 (1960–1), 1082.

⁸⁷ R. Cooter and S. Sturdy, ‘Science, Scientific Management, and the Transformation of Medicine in Britain c. 1870–1950’, *History of Science*, 36 (1998), 422–4, 430.

⁸⁸ Tate, *op. cit.* (note 79), 1091.

⁸⁹ ‘Call to Minister for Research into Tonsil Operations’, *The Times*, 17 January (1968), 13.

⁹⁰ Mold, *op. cit.* (note 8), 234–5.

to the sheer frequency of tonsillectomy. Following support from Labour MPs, NAWCH exerted political pressure upon the Minister of Health to condemn restrictions that had no 'medical justification'. The Minister sent a nationwide memorandum that used Manchester hospitals as an example of poorly managed visiting rules. However, by 1967 there had been no 'radical improvement' in hospital restrictions. Children undergoing tonsillectomy were still subject to significant limitations, to some extent because almost half were accommodated on adult ENT wards for stays of up to ten days.⁹¹

Visiting restrictions were so contentious in this period because theories of child development that emphasised the importance of the mother–child relationship became popular. Child psychiatrist Donald Winnicott was especially influential, broadcasting through the British Broadcasting Corporation (BBC) radio almost sixty times. During the war, the BBC was the foremost consolidator of cultural unity: in 1945 there were 10.8 million radio licenses distributed across social classes.⁹² Winnicott exploited this vast audience using an intimate style that negotiated between technical and accessible language to directly address and advise the listener.⁹³ He built on a public understanding of psychiatric theory that had 'percolated' in British culture from the 1930s.⁹⁴ Winnicott's ideas aligned with a greater movement in child psychology summarised by Denise Riley in 1983 as 'Bowlbyism', referring to the popularisation of John Bowlby's theory that maternal attachment was integral to a child's psychological well-being.⁹⁵

The experience of the Second World War shaped Bowlbyism, because Winnicott and other proponents served as consultants to evacuation projects. The war also helped to popularise Bowlbyism, as mass evacuation cultivated anxiety regarding the psychological effect on children of separation from home and mother.⁹⁶ Amongst fears of recurrent international competition and racial intolerance, Bowlbyism presented a childcare style which could develop the social relationships necessary for modern democratic society to avoid further conflict.⁹⁷ This led to the post-war domestication of the child's landscape, as the 'ideal' childhood space became the home, where a bond with the mother could be cultivated, rather than the isolated 'institution'.⁹⁸ Simultaneously, mothers in the home were reconstructed as protectors of the 'tranquil democratic citizenry' of the future which would consist of the psychologically fragile children now in their care.⁹⁹

Meanwhile, contemporary medicine, the practice of tonsillectomy, and restrictive visiting times seemed archaic and harmful to this hopeful future.¹⁰⁰ As an inherently gendered social movement, NAWCH sought to meet a new maternal responsibility, and so campaigned to reduce visiting restrictions. Their efforts intensified around the publication of Winnicott's best-selling child care manual, *The Child, the Family, and the Outside World*

⁹¹ 'Call to Minister', *op. cit.* (note 89), 13.

⁹² Michal Shapira, 'Psychoanalysts on the radio: domestic citizenship and motherhood in postwar Europe', in J. Regulaska and B. Smith (eds), *Women and Gender in Postwar Europe: From Cold War to European Union* (London: Routledge, 2012), 71–2, 75, 74.

⁹³ Anne Karpf, 'Constructing and Addressing the "Ordinary Devoted Mother"', *History Workshop Journal*, 78, 1 (2014), 93–5; 'From Donald Winnicott to the Naughty Step', Archive on 4', *BBC* (2013).

⁹⁴ Karpf, *ibid.*, 97; Thomson, *op. cit.* (note 7), 7.

⁹⁵ Thomson, *ibid.*, 79.

⁹⁶ *Ibid.*, 16–7.

⁹⁷ *Ibid.*, 82.

⁹⁸ *Ibid.*, 16–7, 5–6.

⁹⁹ Shapira, *op. cit.* (note 92), 74.

¹⁰⁰ 'Call to Minister', *op. cit.* (note 89), 13.

(1964).¹⁰¹ The popularity of Bowlbyism in a context of post-war uncertainty about the future encouraged NAWCH to see tonsillectomy as a coercive cause of personal and social instability. By attempting to overcome visiting restrictions for children, NAWCH sought to domesticate the hospital's institutional environment and supply maternal care, alleviate any psychological distress, and support a stable future for the child and the nation.

Press coverage also began to draw attention to the psychological sequelae of tonsillectomy. Articles advocated Bowlbyist ideas, suggesting that isolation and post-operative pain both upset children and retarded their development.¹⁰² Such emotive accounts cultivated mass opposition to the operation. Concerns about psychological damage also arose from the medical profession. The 1968 World Congress of Anaesthesiologists in London received a paper investigating the 'emotional disturbances in children having tonsillectomy'. It found 'moderate to severe' disturbance in half of the children observed.¹⁰³ As discussed earlier, anaesthetists were often more conservative in their attitudes towards the operation than surgeons. Now they joined journalists and activists in drawing attention to the psychological sequelae of tonsillectomy, transforming 'tonsil children' from infants emancipated from disease into victims of medical paternalism.

Surgical waiting lists became a major political and social concern in the 1960s. During debates in the House of Commons, tonsillectomy held an ambiguous position: simultaneously pervasive and obscured. In 1969 Dr John Dunwoody boasted that at the Hull Royal Infirmary over 40 % of surgery outpatients waited less than 3 months – but deliberately excluded tonsillectomy delays.¹⁰⁴ As the efficiency of the NHS was questioned, waiting lists caused frustration for children and parents, and could cause failure for politicians. Tonsillectomies constituted between 20% and 50% of surgical waiting lists, so to include them would worsen figures and undermine confidence in the NHS.¹⁰⁵ This 'vanishing trick' was not addressed by politicians – the length of tonsillectomy lists were taken for granted.

Not all condemned waiting lists, however. Manchester hospitals seemed inefficient, but in 1967 the chair of the Hospital Board claimed that individual patients received more time and care. He claimed to have seen many American throats, but no tonsils, and hoped that waiting would prevent this tonsillectomy 'habit' from pervading Britain.¹⁰⁶ Pead agreed that delays could reduce the number of children undergoing tonsillectomy. She suggested a 'two-man team' of otorhinolaryngologist and paediatrician could review waiting lists and remove individuals who recovered.¹⁰⁷ Even clinicians agreed: one surgeon joked that by condemning tonsillectomy to the 'Archives of Folk Medicine', waiting lists could be overcome.¹⁰⁸ Disenchantment with the conditions of health care practice encouraged practitioners to criticise procedures that were previously ubiquitous.¹⁰⁹

¹⁰¹ Karpf, *op. cit.* (note 93), 82.

¹⁰² Mary Miles, 'A Child's Fears in Illness', *The Observer*, 13 April (1969), 31.

¹⁰³ 'Anaesthetists to Discuss Toxic Effect', *The Times*, 9 September (1968), 2.

¹⁰⁴ 'Written Answers (Commons) of Monday, 15th December, 1969', 793 (1969–70), 209.

¹⁰⁵ 'Commons Sitting of Wednesday, 10th December, 1969', 793 (1968–9), 499; 'Written Answers (Commons) of Tuesday, 4th November, 1969', 790 (1969–70), 117.

¹⁰⁶ 'Operation Waiting Lists to be Reviewed', *The Guardian*, 25 October (1967), 4–5.

¹⁰⁷ 'Call to Minister', *op. cit.* (note 89), 13.

¹⁰⁸ A. Craig, 'Cutting Out Tonsillectomy', *The Lancet*, 292, 7582 (1968), 1349.

¹⁰⁹ 'Commons Sitting', *op. cit.* (note 105), 453.

ENT surgeons maintained their commitment to tonsillectomy. To them, waiting lists demonstrated that the MoH had its 'head-in-the-sand' as the ENT service did not receive the 'attention it deserves' – Britain had one of the lowest number of ENT consultants per capita in Europe. They thought tonsillectomy played an integral role in 'reducing morbidity', but echoed colleagues from decades earlier by arguing that during busy clinics it was easier to recommend tonsillectomy than explain their refusal 'at length'.¹¹⁰ Disciplinary allegiances led surgeons to support tonsillectomy, which was symbolic of their speciality, and use waiting lists to call for greater resource provision.

Tonsillectomy became a symbol of anxieties about health care provision, including efficiency and migration. In the 1960s the MoH and the NHS developed a medicalised and politicised response to immigration which conflated race with disease risk.¹¹¹ In a context of broader concern with male 'primary migrants' of working age, anxiety developed towards NHS staff sourced from former colonies.¹¹² The perceived risk posed by immigrants was extended from infection to medical incompetence, and cartoons such as figure 2 demonstrate a mistrust of immigrant doctors within concerns about the suitability of the NHS.¹¹³ Tonsillectomy acted as a cultural resource to frame and understand these concerns, but was also re-framed by them, becoming associated with medical incompetence, fringe practice, and danger.

By the late 1960s, tonsillectomy was predominantly utilised to prevent acute tonsillitis. However, new antibiotics had rendered tonsillitis 'rarely a serious condition', suggesting that medical practice had moved technologically beyond a need for surgery. Medical researchers juxtaposed this 'reality' with a supposed lay belief: that tonsillectomy was a panacea able to cure any deficiency.¹¹⁴ However, newspaper articles from this period demonstrated a nuanced understanding of medical practice, acknowledging 'ill-conceived opinion and emotional argument' and an 'astounding' lack of research regarding tonsillectomy.¹¹⁵ Although tonsillectomy had been routinised as an 'inevitable fact of life', health care activism had put medical practice 'under the microscope' and made the 'disagreement' among doctors and 'confusion' among patients unacceptable.¹¹⁶ Rising NHS costs made financial considerations paramount. As the annual cost of tonsillectomy was 600 times greater than that of an investigation into its efficacy, the lack of evidence for its benefit was especially unsatisfactory.¹¹⁷

Simultaneously, NAWCH diversified their efforts to encompass broader health consumer issues.¹¹⁸ In 1968 they issued a memorandum to the Minister of Health expressing doubt regarding the value of tonsillectomy and encouraging research.¹¹⁹ Politicians began to debate the merits of the operation, often using emotive language – for example, one Liberal Member of Parliament (MP) compared the concept of

¹¹⁰ T.J. Wilmot, 'Cutting Out Tonsillectomy', *The Lancet*, 293, 7586 (1969), 155.

¹¹¹ Roberta Bivins, *Contagious Communities: Medicine, Migration, and the NHS in Post War Britain* (New York: Oxford University Press, 2015), 62 168–9.

¹¹² *Ibid.*, 227.

¹¹³ Raymond 'Jak' Jackson, 'You're Sure He Speaks English? I Only Came in for My Tonsils!', *Evening Standard*, British Cartoon Archive, University of Kent: 14854 (21 February 1969).

¹¹⁴ Frank Robson, 'Having out Tonsils "May Be Pointless"', *Daily Express*, (3 October 1969), 13.

¹¹⁵ *Ibid.*, 13.

¹¹⁶ Shirley Lewis, 'Tonsils – in or out: A Survey by Shirley Lewis', *The Guardian*, 17 January (1968), 8.

¹¹⁷ Rudolf Klein, 'The crises of the welfare states', in R. Cooter and J. Pickstone (eds), *Companion Encyclopedia of Medicine in the Twentieth Century* (Hoboken, NJ: Routledge, 2013), 158; Lewis, *ibid.*, 8.

¹¹⁸ Mold, *op. cit.* (note 8), 236.

¹¹⁹ Lewis, *op. cit.* (note 116), 8.

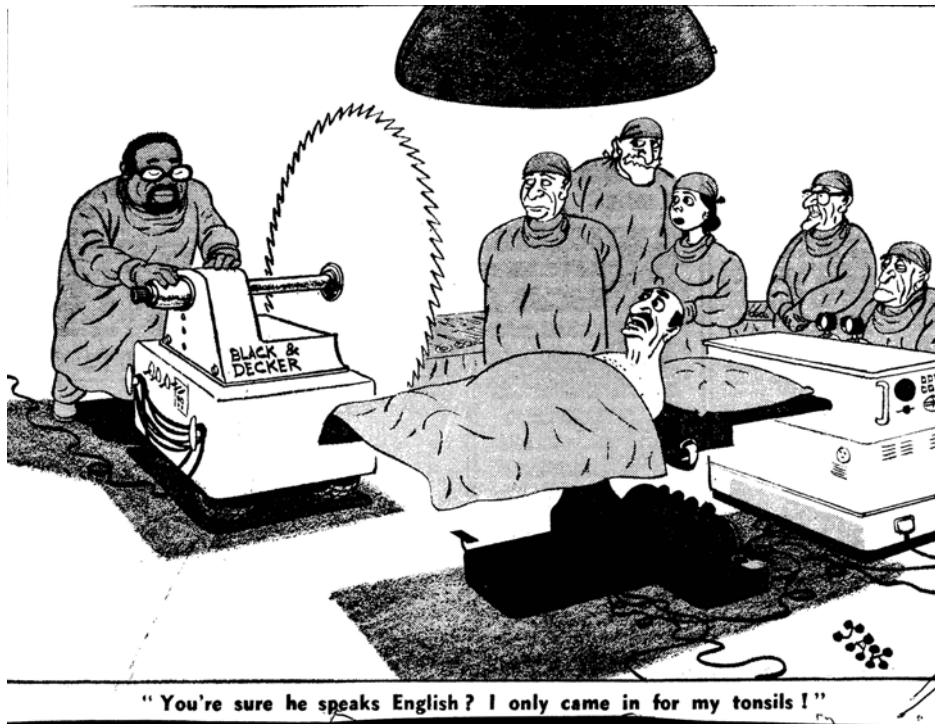


Figure 2: Raymond 'Jak' Jackson, 'You're Sure He Speaks English? I Only Came in for My Tonsils!', *Evening Standard*. Image courtesy of Solo Syndication/Associated Newspapers Ltd., British Cartoon Archive, University of Kent: 14854 (21 February 1969).

private tonsillectomy to 'blackmail'.¹²⁰ NAWCH, alongside journalists and researchers, demonstrated assumptions underlying tonsillectomy and helped transform the tonsil problem from a practical issue into a moral concern. The psychological, personal and financial effects of tonsillectomy were examined, and the operation was reframed as political and damaging, to justify clinical research.

For decades doctors opposing tonsillectomy demonstrated the variability in operation rates between regions and social classes to suggest the operation was irrational. In the late 1960s, the idea that tonsillectomy was 'traditionally' middle class reached journalists: 'being born with a silver spoon and going to public school' was considered tantamount to 'invitation to the otolaryngologist's chair'. Articles in the mainstream press accused tonsillectomy of being a 'fashionable' 'status symbol', as rates seemed to increase after public figures underwent the operation.¹²¹ In 1964 Ringo Starr underwent tonsillectomy, and a spate of cartoons satirised his disembodied tonsils as a fetishised commodity, drawing allusions to surgical faddism (figure 3).¹²² As tonsillectomy was associated with fashion, it became reframed as frivolous and of aesthetic, not medical, value.

¹²⁰ 'Commons Sitting', *op. cit.* (note 105), 476.

¹²¹ Lewis, *op. cit.* (note 116), 8.

¹²² Raymond 'Jak' Jackson, 'Don't Just Stand There – They're Wanted at Sotheby's', *Evening Standard*, British Cartoon Archive, University of Kent: 06413 (3 December 1964).



Figure 3: Raymond 'Jak' Jackson, 'Don't Just Stand There – They're Wanted at Sotheby's', *Evening Standard*, Image courtesy of Solo Syndication/Associated Newspapers Ltd., British Cartoon Archive, University of Kent: 06413 (3 December 1964).

Medical fashions could be just as problematic, as shown by a 1966 article in the *Drug and Therapeutics Bulletin*. This was published for doctors by the Consumer Association, which promoted informed consumer choice. It argued only ten per cent of tonsillectomies were recommended under 'clear indications', while the rest were attributable to the 'enthusiasm' of surgeons and medical fashions. These arbitrary criteria undermined a comfortable belief that tonsillectomy performance was 'enlightened and conservative'.¹²³ Frivolous recommendation by medical practitioners was thought to be just as possible and dangerous as frivolous demand by parents.

Medical professionals, advocacy groups and mainstream journalists strategically emphasised the uncertainty surrounding tonsillectomy to obtain state interest in a context where rationalisation of medical provision was sought. Their arguments persuaded and were reiterated by politicians across the political spectrum as MPs challenged the Minister of Health in the late 1960s. MPs suggested tonsillectomy caused unnecessary suffering and occasional deaths, which were especially 'disturbing' because tonsillectomy patients accounted for thirty per cent of children in hospital. This 'expensive fad' seemed to 'monopolise' NHS resources, and MPs argued that the Minister should conduct a 'thorough investigation' to 'discourage' the operation and protect children and finances.¹²⁴

¹²³ 'Tonsillectomy and Adenoidectomy in Children', *Drug and Therapeutics Bulletin*, 4, 23 (1966), 89–90; Lewis, *op. cit.* (note 116), 8.

¹²⁴ 'Commons Sitting of Tuesday, 13th February, 1968', 758 (1967–8), 1134–5; 'Commons Sitting of Monday, 24th November, 1969', 792 (1968–9), 13.

However, the Minister preferred to ‘wait and see’ and allow doctors to practise according to their judgement. This unpopular position changed when the Department of Health and Social Services (DHSS) was established and a new Secretary controlled medical research.¹²⁵ This Secretary was more sympathetic to the complaints, and hoped that state research could eventually be fruitful. In a context of anxiety about NHS funding, effective large-scale research projects seemed more appealing than continued waste of resources.

Alex Mold has shown that in the 1960s and 1970s the patient was repositioned as a political actor in British health care. Tonsillectomy was simultaneously repositioned, becoming associated with medical, political, and moral complaints. In post-war Britain, the operation became more visible, divisive and potent as it breached its disciplinary boundaries and was associated with anxieties about children and the meaning of childhood. Although NAWCH did not at first self-identify as a consumer group, it emphasised the autonomy of the patient and family and entangled practical considerations with concern for the mental well-being of child patients. This came alongside a gendered assumption that responsibility for care of sick children lay within the maternal sphere.¹²⁶ Changes in patient agency occurred as the medical profession became self-aware about the lack of evidence for the benefit of tonsillectomy. In a context of NHS crisis, even routine procedures were scrutinised, and the tonsil problem gained significant political salience. This encouraged state-sponsored research through the MRC, who were tasked with resolving the problem once and for all.

Testing Tonsillectomy: State Attempts to Solve the ‘Tonsil Question’

By the 1970s, pressure from journalists, doctors and politicians had turned tonsillectomy into a political concept potent enough to warrant institutional and state investigation. The global economic turbulence of this decade acted as impetus to streamline public spending, and tonsillectomy was a large cause of expenditure.¹²⁷ However, investigations into its value were ironically impaired by these same limitations on public spending. From the 1950s, state institutions were mobilised by the potential link to poliomyelitis to begin studying the value of tonsillectomy. This interest only grew into the 1970s, when the MRC began major efforts to solve the tonsil problem.

In 1954, Dr J.Z. Garson submitted a proposal for a study on the value of tonsillectomy to the Research Committee of the Royal College of General Practitioners (RCGP).¹²⁸ Garson ran a large, busy practice in Essex but was young and inexperienced: his proposal was considered ‘woolly’ and required three redrafts before a working plan was agreed upon.¹²⁹ This plan attempted to complete a randomised control trial (RCT – the highest form of clinical evidence)¹³⁰ with children randomly allocated to either tonsillectomy, antibiotic treatment, or no therapy.¹³¹ As David Jones has shown, the positions of protagonists are

¹²⁵ Anthony Tucker, ‘Tonsils Removal Can Be a Fad’, *The Guardian*, 14 February (1968), 1.

¹²⁶ Mold, *op. cit.* (note 8), 225–7, 238, 236–7.

¹²⁷ Klein, *op. cit.* (note 117), 155.

¹²⁸ Letter from Robin Pinsent to Harold Himsworth, The National Archives (hereafter ‘TNA’), FD23/619 (28 March 1957).

¹²⁹ Brandon Lush, ‘Request for Advice From College of General Practitioners’, TNA, FD23/619 (16 April 1957), 1; *Ibid.* (note 128).

¹³⁰ Jeanne Daly, *Evidence-Based Medicine and the Search for a Science of Clinical Care* (Berkeley, CA, and London: University of California Press, 2005), 100.

¹³¹ J.Z. Garson, ‘Draft IV: A Study of the effects of Tonsillectomy and Adenoidectomy’, TNA, FD23/619 (1956), 4–5.

often stable before and after the performance of RCTs, irrespective of their pre-eminence in clinical evidence and their findings.¹³² Garson's critics recognised this and worried that if the study was not focused enough, it would allow proponents of the operation to interpret it as they chose – for example as endorsing tonsillectomy indiscriminately, rather than for selected cases.¹³³

Another problem was indicated by two memoranda by the College Solicitor (a lawyer employed by the RCGP) which affirmed the ethical considerations when conducting trials on children. Specifically, each treatment option must be considered of equal benefit for random allocation to be acceptable:¹³⁴ a concept that would later become known as 'clinical equipoise'.¹³⁵ Pre-conceived notions of the efficacy of treatments interfere with the maintenance of clinical equipoise in randomised trials – especially when non-surgical techniques are compared to surgical.¹³⁶ Members of the RCGP had the same difficulty, as antibiotics were so new to Britain that both doctors and patients required reassurance about their use, and leaving children untreated seemed unfair.¹³⁷ Although Garson was 'obstinate' about his proposals, RCGP members considered them unethical, and by 1957 were 'fed up' with him.¹³⁸ Personal, practical, professional and epistemological difficulties combined to make the trial unachievable.

Similarly, from the mid-1950s, the MRC sought to gather information on the operation, having received requests to do so from health administrators since 1948.¹³⁹ The MRC convened six ENT surgeons to agree criteria under which the operation should be recommended. However, researchers described a 'background of resistance' from the surgeons, who seemingly opposed the investigation of tonsillectomy.¹⁴⁰ Sixteen criteria were eventually proposed, but only two had unanimous support.¹⁴¹ Even this minimal progress was lost after the meeting, when surgeons wrote back to withdraw their statements.¹⁴² Consensus meetings have been criticised for vulnerability to poor group dynamics and opaque processes:¹⁴³ this convention was no different, and reached no meaningful conclusions. The experience made the MRC reluctant to deal with ENT surgeons: in 1957, they instead reached out to the enthusiastic GP, Garson. However, after

¹³² Jones, *op. cit.* (note 10), 526–7, 540–1.

¹³³ Brandon Lush, 'Note For File', TNA, FD23/619 (17 October 1957); 'A Study of the Effects of Tonsillectomy and Adenoidectomy', TNA, FD23/619 (no date), 1–3.

¹³⁴ John Mayo, 'Research Studies as Affecting Child Patients', TNA, FD23/619 (1956), 1–4; John Mayo, 'Proposed Study of the Effects of Tonsillectomy and Adenoidectomy', TNA, FD23/619 (1956), 1–3.

¹³⁵ Benjamin Freedman, 'Equipoise and the Ethics of Clinical Research', *New England Journal of Medicine*, 317 (1987), 141–5.

¹³⁶ Cynthia Tang and Thomas Schlich, 'Surgical Innovation and the Multiple Meanings of Randomized Controlled Trials: The First RCT on Minimally Invasive Cholecystectomy (1980–2000)', *Journal of the History of Medicine and Allied Sciences*, 71, 2 (2016), 130–2.

¹³⁷ Garson, *op. cit.* (note 131), 5; 'Experience of Prophylactic Penicillin in Children', TNA, FD23/619 (1956); 'Personal Experience of Prophylactic Penicillin', TNA, FD23/619 (1956), 1–2.

¹³⁸ Letter from Jerry Morris to Brandon Lush, TNA, FD23/619 (11 June 1957); Lush, *op. cit.* (note 129), 1.

¹³⁹ 'Working Group on Adenotonsillectomy: Minutes of the Meeting Held on Tuesday 1 March at 20 Park Crescent, London W1N 4AL', TNA, FD23/4931 (1977).

¹⁴⁰ Letter from Brandon Lush to Jerry Morris, TNA, FD23/618 (25 May 1955); Letter from Harold Himsworth to Hugh Macaulay, TNA, FD23/618 (18 February 1954).

¹⁴¹ Lush, *op. cit.* (note 140).

¹⁴² Letter from Harold Himsworth, *op. cit.* (note 140).

¹⁴³ Stefan Timmermans and Marc Berg, *The Gold Standard: The Challenge of Evidence-Based Medicine and Standardization in Health Care* (Philadelphia, PA: Temple University Press, 2003), 4.

his ambitious proposal, Garson believed that the MRC investigation of ‘snotty noses’ was ‘beneath his dignity’ and refused to help.¹⁴⁴

GPs and ENT surgeons having proved difficult to work with, the MRC also attempted to collaborate with School Medical Officers (SMOs). A member of the MRC, Brandon Lush, used his SMO brother-in-law, A.C. Gee, as a source of information on the procedures of school medical assessments. Gee was strongly opposed to ‘indiscriminate tonsillectomy’, and complained that other SMOs would recommend almost every child for the operation.¹⁴⁵ Noting an opportunity, the MRC began to work with the Principal Medical Officer (PMO) of the Ministry of Education, Peter Henderson. In 1955, Henderson wrote to the Principle School Medical Officers and urged them to advise all SMOs to record the presence or absence of tonsils in children during inspections.¹⁴⁶ The results showed that one fifth of schoolchildren had undergone the operation by the age of twelve.¹⁴⁷ Henderson’s study also highlighted the variability between regions: in East Ham, near London, 25% of children entering primary school had had their tonsils removed, compared to 0.5% in Merthyr Tydfil in Wales. Socio-economic class also played a role: 14.3% of children aged fourteen and over at the Bristol Technical School had their tonsils removed, compared to 37.9% in Bristol Grammar School. These results were met with interest by the MRC,¹⁴⁸ and contributed to a developing dissatisfaction with geographical variation in practice.¹⁴⁹ However, pragmatic difficulty and a lack of political urgency meant that the tonsil problem was considered only sporadically over the next decade.¹⁵⁰

By 1960, three RCTs on the value of tonsillectomy had been conducted. However, their results were contradictory and methodological shortcomings meant that uncertainty remained.¹⁵¹ By 1968, new studies were published that encouraged the leading British epidemiologist Richard Doll to suggest a state-funded trial. That year a ‘select meeting of experts’ concluded that only a small minority of tonsillectomies were truly necessary. However, a full trial was judged not to be ‘feasible’ at that point, and the proposal was rejected.¹⁵²

The political importance of tonsillectomy peaked at the end of the 1960s, as the Secretary of State again asked the MRC to investigate the operation. In November 1970 a joint meeting between the MRC and DHSS was held to agree on a list of ‘objective criteria’ that could help rationalise referral for the operation. They decided that frequent, recurrent attacks of tonsillitis otherwise intractable to treatment constituted the most common indication for tonsillectomy, while gross enlargement and quinsy were appropriate more rarely. Guidelines were an important method of achieving procedural standardisation

¹⁴⁴ Note in file, TNA, FD23/618 (3 April 1957).

¹⁴⁵ Letter from Arthur Gee to Brandon Lush, TNA, FD23/618 (27 December 1956).

¹⁴⁶ Letter from Peter Henderson to Brandon Lush, TNA, FD23/618 (7 November 1957).

¹⁴⁷ Peter Henderson, ‘Frequency of Tonsillectomy in Children’, TNA, FD23/618 (1957), 1–4.

¹⁴⁸ Letter from Jerry Morris to Joan Faulkner, TNA, FD23/618 (26 November 1957).

¹⁴⁹ Timmermans and Berg, *op. cit.* (note 143), 16.

¹⁵⁰ Letter from Wilson Jameson to Joan Faulkner, TNA, FD23/618 (4 December 1957); Letter from Joan Faulkner to George Godber, TNA, FD23/618 (11 December 1957).

¹⁵¹ Archibald Cochrane, *Effectiveness and Efficiency: Random Reflections on Health Services* (London: The Nuffield Provincial Hospitals Trust, 1972), 60–1; see also Timmermans and Berg, *op. cit.* (note 143); Marcia Lynn Meldrum, *Departures from the Design: The Randomized Clinical Trial in Historical Context, 1946–70* (unpublished PhD thesis, State University of New York at Stony Brook, 1994); Daly, *op. cit.* (note 130).

¹⁵² ‘Adenotonsillectomy: Background Note on Previous Efforts to Review the Operation’, TNA, FD23/4930 (no date), 1–3.

in a period when health care resources were scrutinised. They served as a means of self-regulation to maintain autonomy and control costs.¹⁵³ These stricter indications for tonsillectomy were widely circulated and considered by the MRC to be contributing to gradually declining numbers of tonsillectomies.¹⁵⁴

In the 1970s, the MRC was influenced by a study they commissioned from the medical sociologist M.J. Bloor: 'Investigation of Variation in Adeno-Tonsillectomy Assessments between ENT Specialists'. Bloor compared the assessment routines of ten ENT surgeons. These comprised of 'search procedures' to discover pertinent information, and 'decision rules' used to decide whether tonsillectomy should be performed.¹⁵⁵ Bloor suggested the routines varied along seven main parameters:

- (1) The extent to which surgeons sought specific and quantitative values in their history taking – Bloor suggested that more specific questions allowed surgeons to more effectively identify cases that would benefit from tonsillectomy;
- (2) The degree to which history taking made surgeons independent of the assessments of parents or GPs – constructing 'essential' histories;
- (3) The salience given to physical examination compared to the case history;
- (4) The clinical signs given significance;
- (5) The propensity to list patients for review;
- (6) The extensiveness of assessment routine;
- (7) The extent to which different routines were used for different ages of patient.¹⁵⁶

Bloor argued that a 'lack of reproducibility of clinical assessments' made planning a trial challenging. If a study gave a positive result, it would only validate the assessment routines of the surgeon who recommended tonsillectomy.¹⁵⁷

Bloor also wrote a companion study, consisting of an epidemiological analysis of first referrals for tonsillectomy in children. His results contradicted popular opinion by showing that rates varied more within geographical regions than between them. By dividing the object of study into smaller constituents, Bloor brought a new perspective to the problem. He concluded that medical opinion, rather than environmental or class differences, was the main cause of variability in tonsillectomy referral rates.¹⁵⁸ Collins and Pinch have demonstrated that Bloor's articles had an important role in highlighting the inherent uncertainty in medical decision making.¹⁵⁹ The articles explored the space in which medicine works, at the boundary between normality and pathology. By highlighting the variability between different specialist assessments of that boundary, he demonstrated uncertainty where there was thought to be objectivity. Bloor's papers reinforced the doubts

¹⁵³ Timmermans and Berg, *op. cit.* (note 143), 25, 15–21.

¹⁵⁴ 'Adenotonsillectomy: Background Note', *op. cit.* (note 152), 4–8.

¹⁵⁵ M.J. Bloor, 'An Investigation of Variation in Adeno-Tonsillectomy Assessments Between ENT Specialists', TNA, FD23/4930 (no date), 1–2.

¹⁵⁶ *Ibid.*, 2–6.

¹⁵⁷ *Ibid.*, 7.

¹⁵⁸ M.J. Bloor, 'Extract From a Report on an Epidemiological and Sociological Study of Variations in the Incidence of Operations on the Tonsils and Adenoids', TNA, FD23/4930 (no date), 1–3.

¹⁵⁹ Collins and Pinch, *op. cit.* (note 14), 75, 80–1.

of MRC researchers regarding the rationality of the operation, and provided them with a new way of understanding the structural problems concerned.

In March 1976, the DHSS requested an ‘*ad hoc*’ meeting to review the tonsil problem again.¹⁶⁰ This meeting was chaired by the professor of social medicine, George Knox. By now, social medicine was a discipline in decline, but it was still associated with political reform to maximise the overall health of the population.¹⁶¹ Therefore, the appointment of Knox demonstrated the explicitly political aspect of the tonsil problem: it seemed to damage the health of children, so medical practice needed to change at an individual and structural level. This resonated with wider reformist tendencies in medicine and surgery in the late twentieth century.¹⁶² The meeting highlighted a ‘disturbing’ lack of evidence for the benefits of tonsillectomy. Just as Bloor had studied ENT surgeon behaviour, the group advocated investigation of GP and parent behaviour.¹⁶³ The MRC’s Systems Board reviewed the minutes and instead prioritised quantitative over qualitative study – counting the morbidity, mortality and adverse psychological effects of tonsillectomy.¹⁶⁴

The Board also commissioned a ‘working group’ to turn the broad recommendations of the ‘*ad hoc*’ meeting into ‘concrete and feasible’ proposals. A paediatrician, June Lloyd, was chosen to chair the group. Paediatricians tended to oppose tonsillectomy,¹⁶⁵ and Lloyd’s selection both demonstrated the overriding suspicion of tonsillectomy within the MRC, and shaped subsequent research into the operation. The group convened in March 1977, and produced five recommendations which were ratified by the Board.

- (1) Numbers and causes of deaths within 21 days of the operation should be obtained;
- (2) Data regarding short-term morbidities related to the operation should be obtained or studied;
- (3) Data regarding long-term morbidities should be obtained;
- (4) Studies on the immunology of children with frequent sore throats should be expanded;
- (5) Numbers of operations for gross nasogastric obstruction should be obtained.¹⁶⁶

All recommendations pertained to clinical epidemiology, demonstrating the rising importance of quantitative evidence as a method for justifying or discrediting techniques to health policymakers and governing bodies.¹⁶⁷

The first, second and fourth points were considered pertinent for immediate follow-up by the MRC. They succeeded in collecting mortality figures from Regional Health Authorities (RHAs) who recorded them, but suspected that deaths occurring outside the

¹⁶⁰ ‘Working Group’, *op. cit.* (note 139).

¹⁶¹ Dorothy Porter (ed.), *Social Medicine and Medical Sociology in the Twentieth Century* (Amsterdam: Rodopi, 1997), 1–2, 10–11, 15–16, 98, 111–113.

¹⁶² Kneebone and Frampton, *op. cit.* (note 9), 550–2, 554.

¹⁶³ ‘Extract from the minutes of the July 1976 Systems Board meeting’, TNA, FD23/4930 (no date); ‘Ad Hoc Meeting to Review Adenotonsillectomy: Minutes of Meeting Held at 20 Park Crescent, London, W1N 4AL on Monday, 22nd March, 1976 at 2.00 pm’, TNA, FD23/4930 (1976), 14.

¹⁶⁴ ‘Extract from the minutes’, *ibid.* (note 163).

¹⁶⁵ *Ibid.*

¹⁶⁶ ‘Adenotonsillectomy’, TNA, FD23/4931 (7 June 1979).

¹⁶⁷ Daly, *op. cit.* (note 130), 98–102.

hospital were missed.¹⁶⁸ The problem of under-reporting meant that the true cost of tonsillectomy remained uncertain and reinforced the MRC's wariness of the operation.

The MRC contacted epidemiologist Jean Weddell to investigate the second recommendation.¹⁶⁹ Weddell attended the working group, but was unable to perform the study while leaving her current job.¹⁷⁰ She recommended Stuart Donnan, a Southampton University academic, as a replacement, but he was also changing employment, and the 'pressure of work' constrained him.¹⁷¹ After another potential research partner fell through, the MRC stopped trying to perform a study altogether. A member of the working group summarised the situation: many members believed it was important that a 'proper' trial was performed, but all parties were 'quite incapable' of organising one.¹⁷²

Lastly, the MRC considered the immunological literature on sore throats.¹⁷³ As immunologist for the working group, Professor J.F. Soothill was asked about ongoing studies. Soothill had previously expressed frustration at the bureaucracy of the MRC, arguing two tiers of advisory committee was 'ridiculous, obstructive and extravagant'.¹⁷⁴ He put these complaints aside, and directed the MRC to a study suggesting that children with sore throats were immunodeficient.¹⁷⁵ Thus sore throats would be a poor indication for tonsillectomy as patients would probably continue to suffer symptoms, whether or not they were operated on. Immunological studies acted as another resource that the MRC drew upon to support their conclusions.

By the end of the decade, these conclusions were fully formed, as MRC researchers widely considered most tonsillectomies unnecessary. Almost all the accepted criteria for operation had been demonstrated to be problematic. Some MRC members believed the tonsil problem would require a 'special study' to solve, but many contentedly relied on a continuation of declining operation rates since at least 1967.¹⁷⁶ As Tom Meade, Director of the MRC Epidemiology and Medical Care Unit, put it, the issue was of 'priorities', and tonsillectomy was no longer considered a priority.¹⁷⁷ State institutions had been involved in the tonsil problem for over two decades, but pragmatic difficulties were compounded by personal and professional interests and values, political and parental pressure, and bureaucratic structures, making a study almost impossible to mount by any organisation. Tonsillectomy rates continued to decline irrespective of an influential, large-scale study, and the efforts of the MRC faltered as interest in the operation went "cold".¹⁷⁸

Conclusions

The MRC's work was a crescendo in a debate that spanned over a century, and continues today. Before the foundation of the NHS, professional and national interests met powerful

¹⁶⁸ 'Implementation of the Recommendations of the W/G on Adenotonsillectomy', TNA, FD23/4931 (11 May 1978).

¹⁶⁹ *Ibid.*

¹⁷⁰ Note from Helen Duke to Barbara Rashbass, TNA, FD23/4931 (18 November 1980); 'Working Group', *op. cit.* (note 139); 'Adenotonsillectomy', *op. cit.* (note 166).

¹⁷¹ Letter from Stuart Donnan to Barbara Rashbass, TNA, FD23/4931 (13 November 1980).

¹⁷² Letter from Owen Wade to June Lloyd, TNA, FD23/4930 (6 April 1977).

¹⁷³ 'Implementation', *op. cit.* (note 168).

¹⁷⁴ Letter from J.F. Soothill to June Lloyd, TNA, FD23/4930 (7 March 1977).

¹⁷⁵ Conversation between Helen Duke and J.F. Soothill, TNA, FD23/4931 (20 June 1979).

¹⁷⁶ Letter from Tom Meade to Helen Duke, TNA, FD23/4931 (22 March 1979); 'Extract from the minutes', *op. cit.* (note 163), 1–15; *Ibid.* (note 175).

¹⁷⁷ *Ibid.*

¹⁷⁸ Duke, *op. cit.* (note 170).

theories of disease and state health care intervention to elevate tonsillectomy both in number of operations and in cultural prestige. Around the middle of the century, a potential link between poliomyelitis and tonsillectomy energised and organised the opponents of tonsillectomy, and made proponents more cautious. This precipitated proposals for medical reform from within and without the profession, in a context of health care rationalisation. As the NHS entered crisis by the end of the 1960s, criticisms of tonsillectomy from journalists, patient advocacy groups and politicians expanded the tonsil problem beyond professional boundaries. Through the influence of Bowlbyism, tonsillectomy became a threat to the nation, rather than the saviour it was presented as earlier in the century. The tonsil problem became salient enough to engage the MRC, and for decades attempts were made to produce solid recommendations regarding the operation. However, no definitive trial could be mounted, and even the seeming impossibility of this project went some way to reinforce scepticism about the value of the operation.

The tonsil problem was shaped by financial, professional, military, national and moral interests and values; the structure and concerns of health care provision that encompassed vertical calls for rationalisation and grassroots pressure against paternalism; and influential theories of child development and infectious disease. To understand the rise and decline in the popularity of tonsillectomy, these multiple factors must be considered. Christopher Lawrence and Tom Treasure have noted that surgeons changed surgery, and used it to change the world.¹⁷⁹ For tonsillectomy, this statement can be elaborated: it was changed by diverse factors, and was used not only by surgeons, but also journalists, patient-advocates and politicians to change their worlds. Tonsillectomy was potent not just as a material intervention in patients' bodies or a way to get rich, but also as a rhetorical symbol that could be used to argue for reform of medical practice or health care structures. The patient-consumer movement did just this, profoundly shaping the individual medical encounter, medical structures and how health care was perceived. In doing so, they played an important role in the decline of tonsillectomy.

The case of tonsillectomy has also shed more light on the changing nature of paediatric medicine throughout the twentieth century. As Jonathon Gillis has noted, this medical encounter is exceptional, as the child-patient relies on a third party to recount their history. A unique dynamic emerges, where the balance between physical examination and history is weighted towards examination, and the burden of medical uncertainty is placed under the practitioner's responsibility.¹⁸⁰ The nature of the paediatric medical encounter was shaped by perceptions of childhood, but also shaped how perceptions evolved, as the child was reconstructed as an invaluable and vulnerable individual.

This article has formed the first stage of a social and cultural history of tonsillectomy in Britain. It has demonstrated the value of tonsillectomy as a case study and revealed fruitful avenues of future research. The patient-consumer movement had an integral role in shaping tonsillectomy discourse, but was not representative of the whole population. Analysis of differential positions on tonsillectomy regarding class, ethnicity and gender would be valuable. A comparison between the historical experience of tonsillectomy and that of other 'routine' operations like appendectomy would help understand the British medical experience, and demonstrate whether the observations in this article are generalisable. Emm Barnes' work on childhood leukaemia has demonstrated the value of

¹⁷⁹ Lawrence and Treasure, *op. cit.* (note 4), 653.

¹⁸⁰ Gillis, *op. cit.* (note 18), 491–2, 507–10.

finding the child's voice in paediatric medical history, by providing a rich understanding of the experiences of families with chronically ill children.¹⁸¹ In the case of tonsillectomy, finding the child's voice would provide a more complete picture of how the operation impacted individual families and children.

Events in the twenty-first century have shown that new tonsil problems can emerge. In the last decades of the twentieth century, novel methods of tonsillectomy such as coblation and laser surgery were developed. However, the National Post Tonsillectomy Audit has analysed complication rates of different operative methods, and concluded that 'cold steel' techniques are safest. Thus, a new problem arose: should the profession admit that technological progression does not always produce better outcomes, and should it revert to what were increasingly considered outdated techniques? Around the turn of the century, a link was made between tonsillectomy and variant Creutzfeldt–Jakob disease – colloquially known as 'mad cow disease'. Researchers suggested that the disorder could be spread through tonsillectomy instruments. This precipitated negotiation over tonsillectomy practice, as disposable instruments were introduced.¹⁸² Such recent developments demonstrate that the tonsil problem will continue to develop and stimulate controversy, within medical discourse and society in whole.

¹⁸¹ Barnes, *op. cit.* (note 17), 258–61.

¹⁸² McClelland and Jones, *op. cit.* (note 12), 756–7.