Submitting a project to the British Society for the History of ENT: guidelines exemplified by the history of surgery

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Introduction

Since 1981, the British Society for the History of ENT (BSHENT) meets annually on the first Thursday of December at the Royal Society of Medicine. Usually, twelve presentations are heard, with a prize of a one-year subscription to *The Journal of Laryngology and Otology* awarded to the best junior one, as well as an invitation to submit their paper for presentation. In turns captivating, diverting and eye-opening, it is a unique opportunity to examine our specialty in a different way and welcoming to all from medical students to retired professors, whether or not they are trained in the history of medicine. If you would like to submit an abstract to the BSHENT conference but are not sure how to get started, this article aims to give you some guidance on the process, from selecting a topic to crafting a compelling presentation. To demonstrate this process, some examples are taken from the history of surgery. Firstly, we examine why the history of surgery, and notably the history of ENT surgery, is so important to today's practitioners. We will then discuss how different perspectives shape surgical history, how to identify and engage with historical sources, and how to make your project relevant and appealing by contrasting two different pieces of historical work about a famous 'quack' purporting to cure deafness in 1920s New York.

Why is it useful to study our history?

Surgical history is a fascinating, thought-provoking, and often highly entertaining branch of medical history. But it is more than an interesting footnote to more 'scientific' endeavours: there are numerous reasons why the study of surgical history may complement our clinical practice. Whether looking at surgical techniques, diagnoses, technology or institutions, we cannot change or improve if we do not understand how

the current status quo was reached. How do we effectively address health misinformation such as vaccine hesitancy in our populations if we see such issues as isolated to current time and circumstance, instead of as a recurring pattern since the birth of modern medicine?(1) How can we enhance our communication about hearing aids with the Deaf community if we do not understand their distrust of "cures" for deafness over the last few centuries?(2) How can we meaningfully consent our patients for their laryngectomy if we do not appreciate the providence of bioethics?(3) How can we introduce and disseminate new theatre technologies such as robotics if we have not learned from past successes and failures?(4) How can we claim to address lack of diversity and inclusion in surgery (5) if we don't acknowledge systemic bias inherent since the Enlightenment?(6) In other words, history is an indisputable part of all medical research. How can someone introduce a new idea without knowing the old ones?(7)

Furthermore, history can counteract over-reliance on the 'scientific' aspects of surgery. Since the beginning of the twentieth century, with increasing professionalisation of surgeons, germ theory, industrial pharmacology and ever-more complex technologies, medical and surgical training has been focussed on science. Biochemistry, physiology and later topics such as genetics began to garner greater prominence on curricula; randomised controlled trials brought a new gold standard of evidence and health economics dictated policies and funding.(8) However, medicine is an art as much as a science, and nowhere more so than in surgery, where human skills negotiate the patient/science interface whether in the clinic or theatre. In this arena, the humanities' perspectives have much to offer surgery(9) as will be discussed further in the next section.

How should we tell the history of surgery?

There are many different ways that surgical history can be framed, which are termed "historiographies". It is useful to know about different historiographies so you can evaluate different perspectives in your project and be aware of potential drawbacks of the methods you are using. Most importantly, it will enable you to critically engage with your sources more effectively. History of medicine became a subject of interest to the British during the 19th century. At a time of exploration, industry and Empire, the

Victorians sought historical narratives of heroic (usually male) figures to reinforce cultural and political ideals. Scientists, doctors and surgeons were often presented as inspirational, pioneering individuals whose brilliance had propelled their field forward. The history of surgery was mostly researched and written by surgeons themselves, celebrating the success of their aspirational predecessors and motivating their peers to achieve similar glories. Therefore, surgical – and, on the whole, triumphant - perspectives of surgical history dominated. This way of depicting the history of surgery already exists today.(10)

This began to change in the 1930s when historian Herbert Butterfield published "The Whig Interpretation of History"(11) which accused the Victorian style of historical enquiry of using contemporary values and assertions to judge the past rather than putting it in its proper context, and also of selecting those parts of history which cast the present in a good light, to justify current practices and attitudes. At the time, Butterfield felt that scientists and doctors were not subject to the same biases as politicians or cultural leaders and therefore were not guilty of employing this "Whig" history.

However, by the 1960s, historians were appreciating the social and cultural determinants of health and disease to a far greater extent. They felt that doctor-authored histories focussed too much on the main protagonists and the end result rather than the complex interactions and multiple factors that a social history of medicine could encompass. Changes in healthcare are not brought about by doctors and surgeons alone; patients, the public, society and culture must be considered to put its history in its proper context and avoid "Whig" histories. This was exemplified by the AIDS crisis of the 1980s and 1990s – where strategies to control the spread of HIV were heavily influenced by government policy and social norms, and patient activists played a significant role pushing for research, development and administration of antiretroviral treatments. It is easy to see here that an account of the history AIDS primarily from a doctor's perspective would be considerably lacking, whereas a social history would be far more broad, nuanced, and useful for informing future practices and policies.

As history of medicine expanded as a distinct academic field with the social at its forefront, various historiographies have been employed upon the themes described

above to capture the experience of healthcare users rather than doctors. For example, the history of medicine from below aims to look at the perspectives of those usually overlooked by more 'traditional' histories, for example Roy Porter using Pepys' diaries for a layman's view of renal calculi.(12) Disability histories, borne out of the disability activism movement, give a more holistic view of health than the snapshot of 'disease' observed in a medical clinic.(13,14) Other fields emerging from activist movements are feminist and race histories which can address historical systemic biases in medicine, for example Londa Schiebinger contrasting historical anatomical descriptions of sex and race 'differences'.(15)

However, the history of surgery, as a subsection of the history of medicine, has not evolved to the same extent as the rest of the field; surgery is centred far more around actions and skills than the majority of medical practice, and thus adds another element to the doctor-patient interaction. Some have suggested this can be remedied by thinking of surgery as a technology; a tool that is shaped by and in turn shapes healthcare: from professions and spaces to patients themselves. SCOT (Social Construction of Technology) has thus become a popular way to capture surgical histories, although with the caveat that surgeon and patient pose two end-users in contrast to the single consumer associated with most technologies. (13,16,17) Nevertheless, this approach can also be dispuitable because, a good surgeon often try to find other alternatives to avoid surgery itself. When you ask a surgeon to define what is a "good surgeon", he will often answer: "A good surgeon is the one who does not operate!".

Therefore, if we want rigorous and constructive histories of surgery, it is not enough to give a linear narrative, a timeline, of surgeons and their actions like a late 19th or early 20th Century doctor might. We must employ academic historical frameworks to step away from the purely factual and narrow perspective to give context, comprehensiveness and colour to our enquiries. With this in mind, we move on to selecting and analysing our sources.

Selecting sources

Historical sources are generally divided into primary (original historical material) and secondary (others' work on a topic).(18) Conversely, it is more useful to start with secondary sources to get an overview of the topic, a flavour of how others have

approached it, and if there are outstanding questions, missing information or the potential for original reinterpretations. There are a number of types of secondary sources which may be relevant: journal articles, books, blogs, and even podcasts and documentaries. Look at the authors and their backgrounds or affiliations – are they surgeons, historians, sociologists, policy makers? What historiographies do they employ and what are the strengths and weaknesses of their approach?

For example, a chronological biography of a surgeon written by another surgeon may be quite linear and even "Whiggish"; possibly too critical if the subject's values do not align with the author's own, or overly deferential if they are considered a pioneer of the author's field. But, on the other hand, it could provide useful background information of a main protagonist of your topic. A medical historian's blog on a surgical procedure may give a broader picture of its social, political and cultural context than a mere description of the steps leading to its development. But it may be shaping its narrative to support an argument or an underlying agenda, or be missing the tacit knowledge of certain aspects of surgery. The more secondary sources consulted, the more nuanced and accurate overview can be gained, particularly where these may differ or even contradict each other.

To produce a truly original project, however, engagement with primary sources is vital. It is the only possible way to proceed! These can take many forms: old journal papers (*The Journal of Laryngology and Otology* has archives stretching back to 1887), old textbooks, first-hand accounts (whether written memoirs or oral histories), and archived materials – books, letters, hospital records, even instruments, human remnants, teaching aids as anatomical preparations, and artworks. Some of the latter are freely available, such as the Wellcome Online Library(19) or the Hunterian Museum at the Royal College;(20) others may need special permission to visit and view archives, such as University museums and the National Archives at Kew, but their contents can often be found listed on their websites.(21) Meanwhile, Sue Weir, BSHENT president Neil Weir's wife, has authored a specific guide to medical museums in the UK.(22) These primary sources do not even have to be medical in nature; personal diaries, media such as film and newspapers, censuses and general surveys can all reveal patient and public attitudes towards, and understanding of, healthcare.

Even more so than the secondary sources, primary sources must be interrogated with regards to their authors' motives and perspectives. A surgeon's letter to a colleague may exaggerate their clinical results, a hospital's admission records may oversimplify its patients' complaints, and an organisation's protocol may be constructed on political as well as medical grounds. Descriptions of ailments may not be compatible our current ideas of pathology, unsurprising as they were made at a time of vastly differing theories of bodily systems, and therefore retrospective diagnoses are tenuous at best. And of course, secondary research can aid in the contextualisation of these primary sources.

Therefore, the scope for your historical research is limitless, but for robust analysis of any sources, their biases must be recognised and acknowledged. Where bias may be seen as a negative in scientific investigation, in historical works it is embraced as inevitable, and used to critically engage with sources, shaping arguments and giving fresh insights and alternative perspectives, when combined with an appreciation of different historiographies. But a project that downplays or glosses over its biases may be too insubstantial to achieve its desired impact.

Creating an impactful project

We have already established that a successful submission to the BSHENT requires an awareness of historiographies beyond the linear "Whig" narratives, and critical engagement with primary and secondary sources to construct a compelling picture. But how can this be brought together to make your project stand out? As discussed in the first section in this article, the best projects will provoke reflection on and show relevance to contemporary practices, revealing fresh perspectives to your audience. A recent quality scale, presented in 2015 at the International Society for the History of Otorhinolaryngology meeting, has developed six key points to bear in mind when embarking on such projects as quoted below:

1. *Originality and new material*
2. *Reliance on primary critically treated sources*
3. *Methodology with limitations and bias*
4. *Context dependence*
5. *Interpretation and historical merit*
6. *Impact on everyday practice*(18)

As an example, let us consider two histories of Curtis H. Muncie work (b. 1887 d. 1963) – the famed New York osteopath who supposedly cured a deaf and mute Spanish prince in the 1920s, by digitally manipulating his Eustachian tubes. Subsequently, he amassed a fortune providing this treatment to thousands of patients around the world, whilst claiming his technique could not be performed by anyone else. ENT surgeons Ravi Swamy and Robert Jackler have written a fascinating and entertaining timeline of his career in Otology & Neurotology;(23) they use primary source materials including Muncie's own published work to outline his "outrageous", "unscrupulous" and "egregious" quackery, citing his "avarice" in preying on vulnerable patients as an explanation for the huge profits he achieved.

In contrast is medical historian Jaipreet Virdi's more critical take on Muncie in the Canadian Medical Association Journal.(24) Although she uses similar sources to Swamy and Jackler, and her paper provides similar facts, she examines these sources in the context of 1920's America; the growing Eugenics movement is increasing social pressure on those with perceived disabilities to 'normalise', increasing demand for alternative interventions in areas where modern medicine has 'failed' and allowing practioners such as Muncie to flourish. At the same time, whilst the American Medical Association was becoming more organised, and attempting to distinguish itself from other groups in the healthcare arena, osteopaths were similarly establishing their own standards, research and professional bodies, with Muncie recognised as qualified and experienced by his colleagues, somewhat validating his work. Therefore, Virdi successfully attains each of the six points mentioned above:

Originality and new material, and reliance on primary critically treated sources: both articles look at original primary sources, however they are 'critical' in different ways; the first use these sources to criticise Muncie, whilst Virdi's uses them to understand the processes that shaped his career.

Methodology with limitations and bias: Whilst looking at the vast numbers of patients clamouring for Muncie's treatment, Virdi is at pains to point out that Muncie's self-promotion and compelling claims do not account for the full extent of his success in attracting business.

Context dependence, and interpretation and historical merit: Virdi demonstrates how social factors shaped demand for 'quacks' like Muncie on a background of Eugenic pressures and emergent, opposing professional bodies to explain how he flourished and what attracted so many patients to him.

Impact on everyday practice: Swamy and Jackler's cautionary tale of Muncie the charlatan is wonderfully written with some fantastic illustrations, making for a riveting read, but does tend to judge his actions by today's standards. However, whilst Virdi's article also holds Muncie's dubious ethics to account, she explores social factors driving patient goals and expectations more comprehensively; Muncie is not just an historical villain to disparage, nor merely a yardstick with which to measure progression in medical approaches to deafness, but a demonstration of factors leading to patient disenchantment and exploitation.

Conclusion

In conclusion, the history of surgery is a rich and varied subsection of the history of medicine, incorporating science, technology, health, politics, society and culture. ENT in particular, with its broad patient profile and multiple subspecialties, provides a rich array of resources to be mined by the aspiring ENT historian. Whether utilising instruments, old publications, archived records or patient perspectives, the techniques and approaches recommended here can boost your project's merit and increase your chances of a successful submission.

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