"Lest we forget" is the title of two recent meetings of the Anaesthetic Section of the Royal Society of Medicine at which retired senior anaesthetists related their pioneering work in the development of clinical anaesthesia. These speakers recalled events such as the introduction of tracheal intubation, early days of thoracic anaesthesia, the use of hypothermia and the clinical application of myoneural blocking drugs. They highlighted the part British anaesthetists played in the development of our specialty in the later 1930's and in the 1940's.

It is interesting to note that none of these anaesthetists would, by today's standards, be called a "research worker". Perhaps none of their early papers would now be acceptable at a scientific meeting. Editors might return their manuscripts because of lack of statistical data or a predominance of clinical impressions rather than scientific facts.

Today we have many academic departments, most of which have a number of staff engaged in research. Some of these people have had a training in basic sciences and use their knowledge of physiology, pharmacology, electronics and physics. Sophisticated monitoring equipment is available, computerized records simplify data storage and retrieval, and auto-analysis quickly provides the required biochemical information.

It is not likely that any of today's professors of anaesthesia will make the same impact on our specialty as did Magill or Macintosh. They were anaesthetists with an enquiring mind who sought an answer to their clinical problems and, having found it, made the knowledge available to their colleagues. Similarly, none of today's writers is likely to make as much impact as did Hewer and Lee.

We can look at the 1970's as a decade of consolidation of knowledge of anaesthetic agents and adjuvants and of the physiological changes produced by various techniques. We have looked for better inhalation and i.v. agents, myoneural blocking drugs and analgesics. A variety of forms of neuroleptanalgesia have developed from the lytic cocktail, and spinal and extradural techniques have been re-evaluated. Worthwhile research has been carried out on the mode of action of drugs and on their long-term toxic effects.

Anaesthesia can now be more pleasant for the patient that it was a decade ago. Moreover, the routine work of many anaesthetists has become more interesting in this decade.

While we may not make the advances of the pioneers referred to above, there is still plenty of scope for research. However, research workers need a feed-back from practising anaesthetists. Their limited clinical exposure makes it unlikely that they themselves will come across clinical problems which require investigation. Prolonged suxamethonium apnoea, tissue damage after arterial injection of thiopentone, jaundice after repeat anaesthesia and hypersensitivity to Althesin are only a few of the pharmacological problems which were first noted by practising anaesthetists. A record sheet, clipboard and pen or pencil are readily available to every anaesthetist and were the main tools of some of the pioneers of our specialty. Good clinical notes can reveal a lot of useful information and show the research worker the field to which he should direct his efforts. Many of the new drugs, anaesthetic machines and ventilators evaluated in the seventies were the brainchild of the pharmaceutical or equipment industries. Let the clinicians document the failings of our available agents or machines and the companies will know wherein lies the most profitable field for research. Proper feed-back from clinicians to research workers and industry will make research relevant to all concerned.

John W. Dundee